HIV PREVENTION STRATEGIC PLAN FOR FEDERALLY FUNDED HIV PREVENTION PROGRAMS IN KANSAS

2004

Draft

Developed by the
Kansas HIV Prevention Community Planning Group

In Collaboration and Partnership with the
Kansas Department of Health and Environment
HIV/STD Section

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PREAMBLE

The HIV Prevention Community Planning Group (CPG) is committed to a variety of strategies to take on the challenges required to reduce and eliminate HIV infection. Our team acknowledges the needs and recommendations of communities decimated by this disease. It is imperative that we continue to better prepare for the future by exploring innovative methods of working together to confront our vision of a world without HIV infection. The CPG is finding through its work that the association of HIV/AIDS with gay, bisexual, transgender, males-who-have-sex-with-males, injection drug users, HIV positive individuals, and people of color, greatly hampers the efforts of communities to respond to the epidemic. It is our contention that unaddressed issues of homophobia, racism, and sexism remain as unseen factors in the spread of AIDS. These issues must be properly and adequately addressed as the basis of an objective, focused response to the epidemic.

We also believe that:

Effective harm reduction, outreach, and needle exchange programs are necessary for prevention efforts focused on injection drug users.

Advocacy strategies and media efforts by people living with HIV infection increases familiarity, helps lessen stigma, reduces discrimination and fosters acceptance by making the epidemic more realistic, non-mythical and more visible.

Effective strategies for preventing disease progression and secondary infections should be an integral part of all prevention efforts.

GLOSSARY OF TERMS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ARC	American Red Cross
BEDP	Bureau of Epidemiology and Disease Prevention
CARE	Comprehensive AIDS Resources Emergency Act
CBO	Community Based Organization
CDC	Centers for Disease Control and Prevention
CPG	Community Planning Group
CTR	Counseling Testing Referral
CTS	Counseling and Testing Site
DIS	Disease Intervention Specialist
DOC	Department of Corrections
Epidemiology	The study of disease patterns in populations
GLI	Group Level Intervention
HC/PI	Health Communication/Public Information (type of intervention)
HD	Health Department
HE/RR	Health Education & Risk Reduction
Het Sex	Heterosexual sex; all high risk sex between a male and a female. As used in this profile, it generally refers to the risk behavior of sex with a bisexual male, IDU or person known to be HIV positive.
HIV	Human Immunodeficiency Virus
IDU	Injection drug use; illegal drugs, or drugs being used without prescription administered into the body with a needle.
ILI	Individual Level Intervention
KANP	Kansas AIDS Networking Project
KDHE	Kansas Department of Health and Environment
LHD	Local Health Department
MSM	Men who have sex with men, whether they identify as homosexual, heterosexual, bisexual, or transgender. As used in this profile, it generally refers to the risk behavior of unsafe, unprotected male to male sex.
MSM/IDU	Men who have sex with men (whether they identify as bisexual, heterosexual, or homosexual) and also inject drugs.
OES	Office of Epidemiologic Services
Opportunistic Infection	A disease caused by agents that are commonly in our bodies or in the environment, but cause disease only when the immune system becomes depressed.

PIR	Parity Inclusion & Representation
Prevalence	The estimated total number of cases at a specific point in time
Prevalent Cases	For this document, prevalent cases are those people presumed to be living with HIV or AIDS. If no date of death is reported for an individual, that individual is presumed to be still living.
PCM	Prevention Case Management
STD	Sexually Transmitted Disease

Chapter 1

Overview of the Community Planning Process

THE COMMUNITY PLANNING PROCESS

HIV prevention community planning is one of nine required essential components of a comprehensive HIV prevention program. The purpose of HIV prevention community planning is to improve HIV prevention programs by strengthening the scientific basis, community relevance and population or risk based focus of HIV prevention interventions in each project area.

In 1994 the Kansas Department of Health and Environment (KDHE) began the process of HIV Prevention participatory community planning using funds provided by the federal Centers for Disease Control and Prevention (CDC). HIV Prevention Community Planning is an ongoing process whereby KDHE and members (or representatives) of communities /populations at-risk for HIV infection set priorities and develop goals and objectives designed to promote effective HIV prevention programming. Kansas has one statewide HIV Prevention Community Planning Group (CPG) that is responsible for creating a comprehensive statewide prevention plan. **The structure and processes of the CPG are governed by the Community Planning Group By-Laws (See Appendix 1).**

In year two of prevention planning, the CPG restructured itself into five committees to make it more efficient and facilitate the inclusion of communities across Kansas. The five committees were made up of three to four CPG members each. The rest of the committee is composed of community members across Kansas who have an interest or expertise in the affairs of that committee. Membership on all committees is flexible and on-going. Committees complete a series of necessary planning tasks identified by the CPG. In 2001 the CPG voted to make changes in the original committee structure. At present the committees are:

- Programs and Strategies
- Membership, Recruitment and PIR
- By-Laws
- Evaluation

In addition to these standing committees, In 1998, the CPG created task force committees meet special concerns in the following areas:

- Youth
- Prison System
- Collaboration with Ryan White CARE Consortia

The Kansas CPG continues to increase its effort to market community planning to diverse populations by:

- Involving community members by making meetings more accessible;
- Gathering information from community members on how we can involve them in the process; and
- Informing service providers about HIV prevention data & recommendations.
- Traveling meeting locations, a multi-day educational retreat, and participant evaluations.

MEMBERSHIP

How are CPG members Recruited and selected?

For Kansas, the need to include the perspectives of the diverse populations in prevention planning, particularly those most affected by the HIV/AIDS epidemic, is paramount. Members on the CPG represent high risk, high prevalence target populations and areas of expertise related to HIV prevention. The Recruitment Committee recruits and selects nominees to the CPG on a statewide basis. Public notice of the nomination process is provided by distributing information through key individuals, flyers, E-mail, targeted publications, announcements at public meetings, and conferences. Based on an inclusion survey of the current CPG membership (membership must be representative of individuals most affected/infected by the epidemic), nominees are selected and asked to interview with the Recruitment Committee. If selected, the nominee participates in an orientation training conducted by the KDHE CPG co-chair and members from the same geographic area. Interested applicants are encouraged to actively participate in the CPG process whether or not they are selected to serve on the 25 member planning group. Any person interested in participating in the Community Planning Process should contact the chair of the Recruitment Committee or the KDHE co-chair, Kathy Donner at 785-296-5223.

What is the current composition of the Kansas CPG Membership?

The demographic distribution of persons comprising the CPG as of July 1, 2003 is shown sumamrized in table one. Other representatives include front line providers of HIV prevention, substance abuse, and mental health services; community based organizations, local health departments, behavioral scientists and health planners. State agencies with member representation are the Kansas Department of Corrections (KDOC), Social and Rehabilitation Services (SRS) for alcohol/substance use services, and the Kansas Department of Education.

Chapter 2

Epidemiologic Profile

EXECUTIVE SUMMERY

The complete HIV/AIDS Epidemiologic Profile is included in its entirety as Appendix 2 of this document. Copies can also be obtained from the HIV/STD Section of the Bureau of Epidemiology and Disease Prevention, Kansas Department of Health and Environment (KDHE) or by calling 785-296-5223. A current version is also available online at the KDHE website http://www.kdhe.state.ks.us/hiv-std/download/epiprofile.pdf. Surveillance data reported and analyzed for the epidemiologic profile includes AIDS and HIV cases reported as of December 31, 2001 and Sexually Transmitted Disease (STD) data in defined populations of Kansas. In addition to the Epidemiologic Profile, a surveillance report newsletter is compiled and distributed semi-annually with the most recent HIV/AIDS STD statistics available. This information is also available on-line at the KDHE website.

Kansas is divided into nine HIV/AIDS case management and Prevention regions (see map on page 10). The regions are not equal in population, geographic size or in the burden of HIV/AIDS infection. The larger population centers are located in northeastern Kansas along I-70 from Topeka (the state capital) to Kansas City, Kansas. However, the largest city, Wichita, is located in the south central part of the state. Much of the rest of the state is rural, having a population density that is about half that of the United States as a whole. Thirty-one of the 105 counties in Kansas are designated as frontier counties having a population density of less than six persons per square mile.

Kansas is considered a low prevalence state for HIV and AIDS. There have been 2,475 cases of AIDS first diagnosed and reported in Kansas since 1983 (as of June 2003). Of those, 51 cases were diagnosed in 2002. There have been 430 people diagnosed and reported with HIV in Kansas since July 1, 1999, when HIV reporting became mandatory. There are 1,021 persons with AIDS and 421 persons with HIV that are known and presumed to be still living in Kansas. Nationally, it is estimated that only about 75% of those infected with HIV are aware of their HIV serostatus.

The number of diagnosed and reported AIDS cases has been steadily declining since 1995. The overall decrease in new AIDS cases may be due to advances in Anti-Retroviral therapy for newly diagnosed HIV cases to slow the progression to an AIDS diagnosis. The sharp decline seen in the most recent reporting year is seen annually as each profile is developed and is most likely due to reporting artifact (statistics do not account for reporting lag) rather than due to a sharp decline in newly diagnosed cases.

There continue to be more men than women diagnosed with HIV and AIDS. Men account for approximately 90% of reported AIDS cases since 1983 but only 79% of HIV cases reported since July 1999. Women account for approximately 10% of reported AIDS cases since 1983 but 21% of HIV cases reported since July 1999. The proportion of women diagnosed with AIDS has been slowly increasing over the past 10 years and women accounted for at least 15% of the AIDS cases diagnosed in 2002, compared to just 6% of the cases diagnosed before 1990. Black women accounted for 46% of all the female AIDS cases since 1999 and represented 27% of the reported Black AIDS and HIV cases for the same time period.

People of color represent a disproportionate number of Kansans diagnosed with AIDS.

Blacks comprise 6% of the Kansas population, but over 21% of the AIDS cases and 23.8% of the HIV cases diagnosed in 2002. A total of 433 (17.7 %) Kansas Blacks have been diagnosed with AIDS since 1983 and 94 (23.4 %) cases of HIV since July 1999. Persons of Hispanic ethnicity comprise 7 % of the Kansas population. For Hispanics, a cumulative total of 160 (6.5 %) cases of AIDS and 49 (12.2 %) cases of HIV have been diagnosed in Kansas. In 2002 alone, 7 (13.7%) AIDS cases and 18 (21.4 %) HIV cases were diagnosed in persons of Hispanic ethnicity.

Nearly 45% of cumulative AIDS cases and 41 % of cumulative HIV cases in Kansas were diagnosed in persons between the ages of 30 and 39. However for 2002, 37 % of new AIDS cases were diagnosed in ages 40-49 and only 33 % were diagnosed in age 30-39. In 2002, 39 % of HIV cases in Kansas were diagnosed in persons between the ages of 30 and 39 and nearly 24% were diagnosed in ages 40-49 (in contrast to 18 % cumulative for this age group). Although small fluctuations in yearly counts may greatly affect these statistics, it would appear that the mean age for both HIV and AIDS diagnosis is increasing, rather than decreasing, counter to national trends.

Unprotected male-to-male sex is still the predominant risk factor reported and accounted for 64% of the cumulative AIDS cases and 45.8% of the cumulative HIV cases. For 2002, male-to-male sex accounted for 37 % of AIDS cases and 38.6 % of HIV cases. In Kansas, HIV is more commonly a sexually transmitted disease than a blood borne pathogen. Unprotected heterosexual sex is the predominant risk behavior cited among women diagnosed with HIV (45 %) or AIDS (70 %), with injecting drugs as the second most common risk factor among the women diagnosed with HIV (24 %) or AIDS (24%). (Females reported 31% “risk not known” for HIV contrasted to 5 % “risk not known” for AIDS.)

Risk behaviors for bacterial STDs are often the same behaviors that put people at risk for HIV. Three quarters of the HIV infections in Kansas are acquired sexually, so STD statistics and trends can indicate populations that are potentially at higher risk for HIV. Prevention efforts targeting sexually acquired disease should lead to a reduction of HIV and AIDS as well as bacterial STDs. The number of cases of gonorrhea and chlamydia diagnosed were more than 10 times that of HIV and AIDS in 2002, indicating a higher prevalence of the bacterial STDs in the Kansas population. As with HIV and AIDS, Blacks and Hispanics are disproportionately at increased risk for bacterial STDs when compared with Whites. Less than 1% of individuals diagnosed with a bacterial STDs report male-to-male sex as a risk behavior.

As in past profiles, Region 8 has the highest cumulative AIDS (832) and HIV cases (150)
reported. Region 1 continues to have the highest prevalence of AIDS (105/100,000 population) and HIV (35.3/100,000). Region 5 had the lowest AIDS prevalence at 12.4/100,000 and region 7 had the lowest HIV prevalence at 7/100,000.

Chapter 3

Community Services Assessment

COMMUNITY SERVICES ASSESSMENT

Data collection related to HIV prevention services has enhanced and improved HIV prevention planning in Kansas. During 2002, an outside contractor, The Jones Institute Of Excellence at Emporia State University, conducted a Community Services Assessment (CSA). The purpose was to survey prevention activities and examine consumers' perceptions of HIV prevention services in Kansas. Sixteen focus group discussions with a total of 141 participants, survey responses from 53 HIV prevention contractors, and surveys received from approximately 182 prevention service clients provided the CPG with baseline data highlighting prevention activities and consumer perceptions. The complete report can be found in Appendix 3 of the Prevention Plan or online at: http://www.kdhe.state.ks.us/hiv-std/download/needs_assess.pdf. The CSA contractor made the following observations and recommendations after collecting and analyzing the data:

- The overall perception from both the focus group members and the mail survey respondents was that Kansas was doing an extremely good job in providing HIV Prevention Services around the state. Ratings of various agency characteristics and HIV Services were very high. However, more advertising, education, and training are needed across the state and there is a desire to have HIV included in sex education and health classes within the schools. Finally, the results indicated that even people who utilized HIV services were not very familiar with all the agencies and resources in their local area.

- Focus group results found that confidentiality and a professional and helpful staff to be important agency characteristics, along with having lots of information, services, supplies, and resources on hand. Advertisement and information on HIV should focus on the real consequences of risky behavior.

- Mail surveys results suggested that health clinics are the predominant type of HIV agency and devote about a third of their budget towards HIV services. These agencies have a diverse staff but more training is needed to deal with diverse populations. Of concern was a seeming lack of a coherent model or theory on which many of these services were based. The surveys also revealed particular areas where agencies could offer new services to better serve their clients such as help with legal and insurance issues, transportation assistance, and dental services.

- Information about HIV should optimally be transmitted through the health clinics by way of clinic staff, counselors, and medical staff. Use of printed literature like pamphlets and brochures was also seen as an effective medium.

- Study recommendations included generally reflected a greater need for HIV advertisements, education, training, and information. Continued support and advocacy from the state government is also needed. Proposed changes to services revolved around the need for more and better models and theories along with improved confidentiality protocols.

Focus Groups

The first step in the process was to identify a diverse number of groups across the state that utilized the various agencies that provided HIV-related services. Input from the KDHE and CPG identified a core list of groups that were very important in obtaining information from. These included:

HIV+ persons
MSMs (males who have sex with males)
IDUs (injection drug users) and other substance abusers
Heterosexuals (especially women)
Sex Industry workers
Incarcerated persons
Family, friends, and partners of HIV+ persons (informal support groups)
At-risk Youth
Minority Groups (primarily African American, Hispanic, and Native American)

A list of 12 questions was developed for use in the focus groups (Appendix B). Demographic information collected included gender, age, race, ethnicity, education, income, sexual orientation and HIV status. The next step was to create an Informed Consent document and receive Institutional Review Board (IRB) endorsement for the research while setting up a pilot group at Emporia State University (ESU). All approvals were received and the first focus group was conducted in mid-February, 2002. The focus groups ended around the first of June and data was collected from a total of 16 groups.The breakdown of the groups is as follows:

Population	# of Groups	Total Participants
College Students	1	10
Hispanic Young Adults	1	8
HIV Positive	2	24
Incarcerated Males	1	15
MSM	4	21
MSM of Color	1	8
IDU/Substance Users	2	21
Youth At Risk	1	4
Women at Risk	2	25
Partners of HIV+	1	5
Total	16	141

The focus group format proved to be a very effective method of obtaining information about HIV-related services and other items of interest. Most groups were very talkative, friendly, and helpful. Below is a final summary of the main conclusions drawn from the focus

groups.

- On average, people already using HIV prevention services are only familiar with two or three HIV-related agencies in their area. The general public's knowledge of such agencies is probably even lower. Clearly, more needs to be done to make people aware of ALL services available in their area.

- Effective agencies have professional, helpful, and knowledgeable staff who maintain client confidentiality and privacy. Having a wide variety of programs and lots of information and supplies (brochures, pamphlets, free condoms, etc.) is also very important.

- The HIV/AIDS message should be transmitted across as many different mediums as possible. However, clients tend to prefer general media (TV and radio), their personal physician, and listening to individuals that have had first-hand experience with the disease. The message must also be targeted to the general public but also to specific groups (use their language) and should be used in junior high sex education classes.

- More education, awareness, and advertising is needed to reach people in the state. The state government must get more involved in delivering the message.

- Local health clinics and HIV-related clinics are the preferred places people want to get tested for HIV. However, there are considerable fears and stigmas attached to the testing process that limit the number of people who make use of their services. This is compounded by the conflict inherent in many religious, anti-drug, and moral groups that speak out against homosexual lifestyles and risky behavior.

- Alcohol and drugs are often contributing factors in the risky behavior that leads to acquiring HIV. However, many feel that there is little that can be done to directly change behavior as there is sufficient information out there, it is just ignored.

- HIV and AIDS must become a state priority. The more successful HIV-related clinics, agencies, and programs should be used as a model for clinics of a similar nature.

Surveys

The remaining summer was spent preparing and analyzing the focus group data and beginning to prepare the mail-out survey. Again, feedback and input were solicited from KDHE and CPG members as to the content of the survey. Two surveys were eventually developed, one for the various agencies and programs that provided HIV-related services in the state and the other for the individual clients who utilized these services. To better involve minority persons, a Spanish version of the client survey was also developed. Copies of the Agency Surveys and both

English and Spanish versions of the Client Surveys can be located in Appendix D.

There were a total of 53 agencies that responded and provided meaningful data to the agency survey. There were also a total of 182 individual clients who mailed back the client surveys. Eleven (or 6%) of the returned client surveys were of the Spanish version. Responses by clients included the following:

Where to Get Tested

The top five most common answers to the question (and the percentage of client respondents who mentioned this) about where you would refer a friend to get HIV testing are listed below:

1. Local Health Department (27%)
2. A Health Clinic (24%)
3. Physicians or Hospital (11%)

The remaining responses all targeted specific clinics or agencies.

Performance of the state in providing HIV services

When asked whether or not the state of Kansas was doing a good job in providing HIV-related prevention services, 67% answered "Yes".

Factors preventing people from using HIV services

The top five most common answers to the question (and the percentage of client respondents who mentioned this) about which factors prevented people from using HIV-related services in your county are listed below.

1. Fear and embarrassment of learning results (26%)
2. Don't know about services or that they should be tested (18%)
3. Fear that others will find out (15%)
4. No available transportation (7%)
5. Are in denial about their behaviors (6%)

What state can do to improve HIV services

The top five most common answers to the question (and the percentage of client respondents who mentioned this) about what the state of Kansas can do to improve HIV-related prevention services are listed below.

1. More advertising and announcements (20%)
2. More educational materials and information (18%)
3. More clinics and outreach programs (14%)
4. Provide more free and low cost services and supplies (9%)
5. Use HIV information in sexual education classes (6%)

Reduction of Risky Behavior and Increase in Testing

The top five most common answers to the question (and the percentage of client respondents who mentioned this) about what can be done to reduce HIV-related risky behaviors and increase testing are listed below.

1. More education and awareness about HIV/AIDS (29%)
2. Better access to testing and free condoms/needles (24%)
3. Show the realities and consequences of HIV/AIDS (16%)
4. Provide more media advertisements (15%)
5. More HIV information in sexual education classes (8%)

The mail-out survey was not perceived to be as effective as the focus groups due to the large numbers agencies and clients who seemed unwilling or uninterested in completing the surveys even after a second mail-out. While the response rates were within an expected range they were still disappointingly low, particularly from the agency perspective. Nonetheless, the mail-out results did provide some very interesting and useful findings. Below are some of the main conclusions drawn from the mail-out surveys: .

- The typical staff is fairly diverse but probably needs additional training to better deliver HIV and AIDS related information as well as interact with minority clients and homosexual clients. ❑ Both clients and agencies are unaware of all the HIV-related agencies, services, and resources available in their local area with clients only being able to name 2-3 on average and agency director only 4 other agencies on average.

- Both agencies and clients felt that the state of Kansas was doing a very good job of delivering HIV services with high (65+%) approval ratings.

- Agencies and clients felt that confidentiality and fear issues were still the main reasons why high-risk individuals did not get tested. However, a lack of awareness about the services also seemed prominent.

- Both agencies and clients felt strongly that more funding, more advertisements, more education, and more awareness are needed to improve the existing condition of HIV services in the state. These in turn were perceived to be the key ways of changing high-risk behaviors.

- Both agencies and clients feel that the most important characteristics to an HIV organization are confidentiality and a professional and friendly staff. It is also important for that organization to provide lots of free or low cost services and supplies and have lots of available educational materials and information.

- The majority of responding agencies did not feel that they were basing their services on a particular model, theory, or approach.

- When both clients and agencies rated agency characteristics, there was a very strong positive consensus that the agencies were performing exceptionally well (consistent ratings above 4.00). In most instances, the clients actually gave the agencies higher ratings than the agency directors and any time there was a significant difference between the rating means, the clients had higher (more favorable) ratings.

- Agency characteristics that were of concern (received lower ratings compared to other areas) were: proximity of the agency to their clients, and whether childcare services were available. Agencies also had comparatively low ratings for the amount of advertising done and the degree to which support

groups were provided.

- When both clients and agencies rated HIV services, there was again, a very strong positive consensus that the agencies had exceptional services. Again, the clients generally gave higher ratings than the agencies suggesting a very positive perception and in the three case where there was a significant difference in the gap analysis, the clients had higher ratings.

- HIV Services that were of concern (received lower ratings compared to other areas) were: transportation assistance, help with legal issues, help with job searches, and help with food. Agencies also had comparatively low ratings for mobile test sites, support groups, help with medication expenses (though clients rated this very high), emergency financial help (clients also rated this high), and agency websites.

- When asked about the which services were currently available, agencies rated HIV Testing, counseling for HIV, providing HIV Literature/Education/Information, experimental therapies, and free condom distribution as most common. Client use of these services was quite similar except for experimental therapies.

- Most agencies felt that the best services to add in the future were: experimental therapies, safe sex seminars, and support groups. Clients felt that the best services to add would be: dental services, additional help with medication costs, help with legal issues, providing financial support for emergencies, help with insurance issues, and more information on HIV as well information on discrimination, housing, and social security issues.

- Both clients and agencies felt that the most effective ways of communicating HIV information to the general public were: health clinics, word of mouth, sex education in schools, brochures/pamphlets, and personal physicians/nurses. Mailing information to people, newspaper ads, and magazines were the least effective ways identified.

- When asked which communication methods they actually used, agencies rated word of mouth, brochures/pamphlets, and sex education in schools very highly. Clients, on the other hand, preferred to get their information though health clinics, word of mouth, and their personal physician.

Gap Analysis

Resource Inventory

In conjunction with the above activities, a rigorous review of the "Directory of Kansas HIV Prevention Programs" (1996) and "Quick Guide to HIV/STD services In Kansas" was conducted, as well as an internet search for agencies providing HIV/AIDS services in Kansas.

The list of agencies compiled from this review were contacted to update information regarding services provided and current address, telephone number, and web site links. The updated information is carried forward in the "Quick Guide to HIV/STD services In Kansas" which is updated quarterly. It can also be found online at: http://www.kdhe.state.ks.us/hiv-std/download/quick_guide.pdf

Chapter 4

PRIORITIZATION PROCESS

INTERVENTIONS

Prioritization

The prioritization process began with technical assistance on methods of prioritization. The CPG agreed to use a method of selecting a set of factors as a basis on which to evaluate each target population, assigning a weight to each factor, rating each target population on each factor, calculating a weighted score (weight x rating), and then adding the weighted scores of the factors together for a total score for the population. The first step was to decide on the target priority populations to be scored. After reviewing epidemiological data, behavioral surveys, CDC and Institute of Medicine recommendations, and the current set of priority populations the CPG selected the following set of target priority populations:

1. MSM: Men who have sex with men.
   - Gay Men
   - Bisexual Men
   - Transgender
   - Men who don't identify as Gay, Bisexual, or Transgender

2. HIV+: Individuals who have tested positive for HIV

3. IDU: Injection Drug Users
   - Individuals who are injection drug users.
   - Individuals who inject substances such as steroids or hormones.

4. SPO: Sex Partners of MSM, IDU, and HIV+
   - Female sex partners of MSM.
   - Male and female sex partners of known IDU's.
   - Male and female sex partners of known HIV+ individuals

5. HET: Heterosexual sex
   - Males and females engaging in heterosexual relationships where risk behaviors or HIV status of their partner is unknown

6. HRB: High Risk Behavior or Vulnerable Situation
   - Non-injection substance users.
   - Homeless
   - Incarcerated
   - Mentally, physically or emotionally compromised
   - Youth
   - Migrant
   - Perinatal

The process of selecting factors and weights is summarized on the worksheet that follows.

Eleven factors were selected as criteria for prioritizing the above six populations. CPG members individually assigned weights to the factors and the results were tabulated to assign the aggregate average to that factor. CPG members were then provided data appropriate for evaluating that factor for each population. The first five factors were evaluated strictly by data from the HIV Surveillance program. The remaining factors were evaluated by each CPG member utilizing the data available for that factor and population. The results were tabulated for an aggregate average

rating and a score was calculated for that factor. The factor scores were then summed to find the total score for that population. After the populations were ranked according to their scores (CDC specifies that HIV+ will be the first priority), the CPG members assigned the percent of resources they want allocated to that population. The results are summarized in Table 1.

Priority	Target Population	Score	CPG Recommended Allocation
1	HIV Positive Individuals	154.2	25%
2	Men who have Sex with Men	155.4	24%
3	Injection Drug Users	123.3	17%
4	Sex Partners Of MSM, IDU, HIV+	105.2	13%
5	Heterosexual	103.4	11%
6	High Risk Behavior/Situation	98.9	10%

Table 1

Interventions

There are seven types of HIV prevention interventions currently in use. They are as follows:

Counseling, Testing and Referral: HIV testing by standard blood drawn samples with pre and post test HIV Prevention counseling and referrals to other services. This testing is usually located in fixed sites (84) such as local health departments and clinics. Test results usually take two weeks, so the problem of follow-up for notification and post test counseling is significant if the client does not return for results. Oral testing eliminates the problem of drawing blood and does not require a fixed site, so it can be used in outreach situations; but results still take two weeks. Rapid testing requires only a finger stick and results are available in about twenty minutes, however it requires a stable environment to conduct the test.

Partner Counseling and Referral: This is a service to counsel, test, and provide referrals to sex and needle sharing partners of HIV+ individuals. For confidentiality reasons, all partner counseling and referral is conducted by state Health Department Disease Intervention Specialists.

Individual Level Interventions: Individual Level Interventions are one-on-one sessions between a Health Education/Risk Reduction Educator and a client to teach HIV risk reduction skills. Interventions are based on theories of behavior change. The design of the intervention may be for one or multiple sessions.

Group Level Interventions: GLI's are designed for small groups of individuals at high risk for acquiring or transmitting HIV infection. The goal is to provide educational interventions that promote and reinforce safer behaviors. Interpersonal skills training and support is provided in negotiating and maintaining safer sexual and needle-sharing behavior. Emphasis is on the relationship between substance use and risky behaviors and referrals to appropriate services

Outreach Interventions**:** Outreach interventions are designed to change individual

behavior by providing motivation, knowledge, risk reduction materials, and referrals to services that support behavior change. Such programs access at-risk individuals on the street, in malls, parks, bars, public sex environments (PSE's), or other community settings. Outreach is directed towards a clearly defined target population. These populations are defined by their demographic characteristics and risk behaviors through the Community Planning Process.

Prevention Case Management**:** Client-centered HIV prevention activity with the fundamental goal of promoting the adoption of HIV risk-reduction behaviors by clients with multiple, complex problems and risk-reduction needs; a hybrid of HIV risk-reduction counseling and traditional case management that provides intensive, ongoing, and individualized prevention counseling, support, and service brokerage.

Health Communication/Public Information : The delivery of planned HIV/AIDS prevention messages through one or more channels to target audiences to build general support for safe behavior, support personal risk reduction efforts, and/or inform persons at risk for infection how to obtain specific services.
Electronic Media: Means by which information is electronically conveyed to large groups of people.
Print Media: These formats also reach a large-scale or nationwide audience;
Hotline: Telephone service (local or toll-free) offering up-to-date information and referral to local services, e.g., counseling/testing and support groups.
Clearinghouse: Interactive electronic outreach systems using telephones, mail, and the Internet/Worldwide Web to provide a responsive information service to the general public as well as high-risk populations.
Presentations/Lectures: These are information-only activities conducted in group settings.

Recommendations for interventions for the target populations were based on the following criteria selected by a CPG committee:

1. Is the intervention reflective of the culture of the intended target population?
2. Is it appropriate for the behavioral and ethnic characteristics of the population?
3. Has the intervention been shown to be effective for the specified target population and did the target population have input in the development of the intervention?
4. Does the intervention have clear and specific goals?
5. Is the intervention based on a behavioral or social science theory?
6. Is the intervention acceptable to the community's norms and values including geographical location?
7. Does the intervention target a specific behavior?
8. Can the intervention be implemented without any significant barriers?
9. Can the intervention be evaluated?

By CPG request, a Behavioral and Social Science Volunteer (BSSV) utilized the above criteria to evaluate interventions in the "Compendium of Proven Effective Interventions" (CDC, 2001) and other more recent interventions found through a data base search. Recommendations were made for Individual, Group and Outreach interventions for each target population. The CPG committee added Prevention Case Management to the recommendations for HIV+ persons and recommended Counseling Testing and Referral, Partner Counseling and Referral, and Health Communication/Public Information for all 6 target populations. The results of this process are shown in Table 2.

TABLE 2: CPG RECOMMENDED INTERVENTIONS	
Target Population: HIV + Individuals	
Intervention Type	Recommended Intervention
Individual Level	Behavioral Intervention (Patterson, Shaw, Semple, 2003)
Group Level	Theory-based Learning (Kalichman, Rompa, Cage, DiFonzo, Simpson, Austin, Luke, Buckles, Kyomugisha, Benotsch, Pinkerton, Graham (2001)
Prevention Case Management	KDHE supervised PCM sites in CBO's, Local Health Depts.
Target Population: Men who have Sex with Men	
Intervention Type	Recommended Intervention
Individual/Group Level	Mpowerment (Kegeles, Hayes & Coates 1996,1999)
Outreach	Community Level HIV Prevention (Community HIV Prevention Research Collaborative, 1997)
Target Population: Injection Drug Users	
Intervention Type	Recommended Intervention
Individual Level	Psychosocial Intervention (Gibson, McKucker, Chesney, 1998, Gibson, Lovelle-Drache, Young, Hudes, Sorensen, in press)
Outreach	(Needle, Coyle, Normand, Lambert, and Cesari, 1998)
Outreach	Substance Abuse Treatment, Networking
Target Population: Sex Partners of MSM, IDU, HIV+	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Outreach	AIDS Community Demonstration Project (CDC ACDP Research Group, 1999)
Target Population: Heterosexual	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Group Level	Project RESPECT (Kamb, Fishbein, Douglas, et. al, 1998)
Outreach	Women and Infants Demonstration Trial (Lauby, Smith, Stark, Person & Adams, 2000)
Target Population: High Risk Behavior/Situation	
Intervention Type	Recommended Intervention
Group Level	NIMH Multisite HIV Prevention Trial
Outreach	Women and Infants Demonstration Trial (Lauby, Smith, Stark, Person & Adams, 2000)

Table 2

Target Population: All of the Above Priority Populations (if appropriate)	
Intervention Type	Recommended Intervention
Counseling, Testing & Referral Service	KDHE supervised CTRS sites in 84 CBO's, Local Health Depts., Clinics, and other Institutional Facilities.
Partner Counseling & Referral Service	KDHE Disease Intervention Specialists
Health Communication /Public Information	Presentations/Lectures, Electronic Media, Print Media, Clearinghouses, Hotlines, Advertisements

Table 2 (Cont.)

These recommended interventions are the basis for all HIV Prevention activities funded with state and federal (CDC) grants beginning July 1, 2004. A competitive grant process will be conducted to solicit HE/RR contractors to implement the Individual, Group, Outreach, Prevention Case Management, and Health Communication/Public Information interventions as recommended above.

Behavior Theory Applied to HIV Prevention Interventions for Priority Populations

Key to the recommendations above is the mandate to utilize interventions based in behavioral science theory. Those theories are as follows:

Diffusion of Innovation: The process by which any new idea or an innovation is communicated to the members of a group or population based on four key components:

1. The actual communication channel (word of mouth, telephone, newspapers, etc);
2. Visible respected opinion leaders who can assist in dispersing the message;
3. Time and process (this is required for the message to reach community members and people receive and accept messages at different time intervals); and
4. The social network to link members.

Research shows that diffusion theory can inform effective intervention for the gay community and injection drug users if the core concepts are appropriately adapted.

Health Belief Model*:* The premise of the theory is that health related behaviors depend on four key beliefs; all of which must be operating for a risk reducing/health promoting behavior to occur. They are:

1. Perceived susceptibility (I could get it);
2. Perceived severity (it could be bad if I get it);
3. Perceived benefits of performing the behavior;
4. perceived barriers of performing the behavior.

Evaluation research of HIV intervention programs based on this theory generally support it usefulness as a behavior change model. By using this model a provider can separately target the beliefs necessary for behavior change and barriers to prevention regardless of the target populations demographic characteristics, as long as the intervention components are culturally

appropriate.

Theory of Reasoned Action: This theory is based on the premise that in order for behavior change to occur, one must have an intention to change and intentions are influenced by two major factors. The first factor is the attitude toward the behavior; and second subjective norms about the behavior. Both attitudes and beliefs toward the behavior, along with the perception of what significant others think an individual should do, influence intentions toward performing a behavior. While other behavior theories target the individual, the theory of reasoned action incorporates the social and interactional aspects of human behavior. This is useful for intervening with sexual behavior which is inherently social in nature.

Social Cognitive Theory: This theory emphasizes that behaviors are dynamic, and influenced by both personal and environmental factors; behavior is learned through direct experience, by modeling others, or through observation. There is a reciprocal interaction of behavior, social and physical factors and that a change in any one of the three factors influences the others. The two primary forces that affect change in these factors are expectancies and incentives. Acquisition of new skills is often required. The chances of a behavior being repeated depend on the person's assessment of it's costs/benefits. Evaluation of HIV prevention interventions that employ social cognitive theory concepts have documented its useful ness as a model for designing programs. Perceived self efficacy to negotiate condom use with partners has proved a strong predictor of sexual behavior change among gay men, adolescents, and college students. Influencing social outcome expectancies to heighten positive social norms for safer sex and drug use likewise has shown to affect HIV risk-taking behavior.

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Chapter 5

GOALS, OBJECTIVES and ACTIVITIES: A 5 YEAR PLAN FOR HIV PREVENTION IN KANSAS

National and State Linked Prevention Objectives

The document "Healthy People 2010", published in November 2000, proposes 17 broad objectives for the prevention of HIV infection and its related illness and death. Concurrently, the Centers for Disease Control and Prevention Department of HIV/AIDS Prevention (CDC-DHAP) and the Institute Of Medicine outlined new objectives and strategies for lowering the rate of new HIV infections.

The Institute of Medicine Report "No Time To Lose: Getting More from HIV Prevention" (November 2001) urged a strategy of six elements: 1) develop an accurate surveillance system focused on new HIV infections; 2) allocating resources to prevent as many new HIV infections as possible; 3) using the clinical setting for prevention; 4) translating research into action; 5) investing in new tools and technologies for HIV prevention; and 6) striving to overcome social barriers.

The CDC-DHAP draft 5-year Strategic Plan for HIV Prevention (January 2002) includes four primary goals: 1) reduce new infections by half in the U.S.; 2) ensure that nearly every HIV-positive individual in the U.S. knows his or her HIV status; 3) expand significantly the number of people with HIV who are linked to appropriate care, prevention, and support services; and 4) assist resource constrained countries with many of the same goals.

More recently (May 2003), in a climate where there is a growing perception that HIV prevention efforts are not making progress, CDC-DHAP announced the initiative "Advancing HIV Prevention: New Strategies for a Changing Epidemic-United States". This initiative addresses specific steps to meeting the above goals with the following objectives: 1) Incorporate HIV testing as a routine part of care in traditional medical settings; 2) Implement new models for diagnosing HIV infections outside medical settings; 3) Prevent new infections by working with people diagnosed with HIV and their partners; 4) Further decrease mother-to-child HIV transmission. These evolutionary documents represent a national critique of historical approaches toward fighting HIV disease and ongoing refinements of how to address deficiencies found. Kansas has paid close attention to this process and dynamically prepared for it in how it has structured its approach and mechanisms for evaluation.

While at first this plethora of goals stated nationally may seem confusing, overlapping and complementary needs emerge. One such need is to extend Counseling and Testing to those who are HIV positive and unaware of their sero-status. Not only are these persons at high risk for transmitting HIV to uninfected individuals, they are deprived of medical services capable of greatly improving their duration and quality of life. Complimentary to this is a mandate to make HIV positive persons the highest priority for HIV prevention efforts beyond testing. Thus increased emphasis is placed on Partner Counseling and Referral, Prevention Case Management and linkages with services such as Ryan White C.A.R.E. One key to meeting this need is HIV named reporting, which has been in effect in Kansas for three and a half years, and contributes to improved surveillance. This surveillance is at the foundation of the ability of the state to effectively evaluate the impact of prevention and care services.

Another common theme (not expressed above) is increased accountability for how HIV Prevention resources are allocated and utilized. This places a great emphasis on Evaluation and Quality Assurance. These are integral to the CQI approach utilized. As noted above, investments in new technologies are required to meet these needs. An example of this is web based evaluation reporting that has been in use for two years in Kansas. This reporting system will be upgraded and expanded to cover Prevention Case Management in 2004. It is the key for responding to the CDC-DHAP evaluation reporting system "PEMS" and the development of quantitative Indicators of program performance. Another example is adoption of advanced

testing technologies such as OraSure oral HIV testing that has been utilized for over two years and OraQuick rapid HIV testing that will be implemented in 2004.

The timing for these new initiatives and technologies could not be better and the program has sought to proactively coordinate statewide efforts for the upcoming multi-year application cycle. The Kansas Community Planning Group is in the final stages of completing a three-year planning process that included a Community Services Assessment, a new set of target prioritized populations and recommended interventions. This information is currently being compiled to write a new HIV Prevention Plan covering the next five years of HIV prevention efforts in Kansas. Concurrent to this, new RFP's will be released in the next month to solicit competitive HE/RR proposals based on the HIV Prevention Plan. Selected proposals will be contracted to start on July 1, 2004. Thus the one unknown for this grant application is that at present we do not know who the contractors will be and exactly what interventions will be implemented. What we are certain of is that these programs and interventions will be consistent with the goals and objectives of CDC-DHAP and the recommendations of the Kansas Community Planning Group. Furthermore they will meet the performance criteria and accountability called for in this program announcement.

Kansas has developed an integrated and linked continuum of prevention and care services put together to support the national objectives and provide quantitative and qualitative data to measure progress toward the goals and objectives. The goals, objectives and targets of this application are interdependent with other program elements to ensure effective prevention and care for HIV and sexually transmitted diseases within the state. The foundation is based upon staff insight anticipating trends in the national approach toward fighting HIV that have developed over the last few years and are indicated below. It is a comprehensive approach. The state utilizes a Continuous Quality Improvement oriented approach to all activities to ensure ongoing improvement of efforts toward the goals. The content of this application illustrates the relative success of the program in laying the foundation to succeed in meeting requirements of the guidance.

PREVENTION PLAN GOALS AND OBJECTIVES FOR KANSAS

Overarching Goal: Reduce the incidence of new HIV infections in the state of Kansas.
Overarching Objective: Reduce the incidence of newly diagnosed HIV infections by 50% in the next five years (2004 -2008).

Goal One: Provide culturally sensitive, appropriate, client centered and affordable HIV Counseling and Testing Services (CTS) and Partner Counseling and Referral Services (PCRS) to individuals at high risk for HIV infection.

Objective One: Increase the proportion and number of people of people at high risk for HIV infection that access CTS services in Kansas.

Objective Two: Increase the proportion of HIV+ persons who know their HIV serostatus. It has been estimated that approximately 25% of HIV + persons are unaware of their HIV positive serostatus. These persons are at risk for transmission of HIV as well as not having access to medical and social services that would improve their quality of life and promote a less risky lifestyle.

Objective Three: Increase the proportion of newly diagnosed HIV+ individuals who access partner counseling and referral services and are referred into appropriate and affordable medical and social services.

Goal Two: Provide culturally sensitive and appropriate client centered Health Education/Risk Reduction services to individuals at high risk for HIV infection or HIV transmission.

Objective One: Increase the number and proportion of Individual" Group and Outreach interventions based on behavioral science theory and proven effective as prescribed in the Kansas CPG Comprehensive Prevention Plan.

Objective Two: Increase the number of individuals and the number of contacts per individual in Individual, Group and Outreach HE/RR interventions as prescribed by the Kansas CPG Comprehensive Prevention Plan.

Objective Three: Conduct Health Communication/Public Information interventions as needed to support other HE/RR activities and inform the general public on HIV prevention efforts.

Objective Four: Demonstrate the efficacy of HE/RR interventions with client level measurable outcomes.

Goal Three: Provide culturally sensitive and appropriate client centered support and referral services for those infected with HIV, those at risk for infection, or those affected by HIV.

Objective One: Provide culturally sensitive and appropriate client centered Prevention Case Management. Increase the proportion of HIV+ individuals who enroll in Prevention Case Management. Demonstrate the efficacy of Prevention Case Management with measurable outcomes.
Objective Two: Increase referrals into services for medical, mental health, substance abuse, housing, job training/employment, education, legal aid, and other services. These services will promote the social capital and well-being of clients and provide support to those infected with HIV, those at risk for infection, or those affected by HIV.

Objective Three: Promote activities that remove the cultural, social and economic barriers that prevent access to HIV / AIDS prevention and care services and lessen stigma and discrimination associated with HIV / AIDS.

Goal Four: Conduct a community planning process in accordance with the Centers for Disease Control HIV Prevention Community Planning Guidance.

Objective One: Maintain a Community Planning Group (CPG) that supports broad-based community participation in HIV prevention planning and whose members reflect the demographics of the HIV epidemic.

Objective Two: The CPG will conduct a process to examine epidemiological data regarding HIV / AIDS, conduct Community Services Assessments, determine priority populations at risk for HIV infection and recommend appropriate interventions for each priority population.

Objective Three: The CPG, in collaboration with the Kansas Department of Health and Environment will develop and maintain a comprehensive HIV Prevention Plan for the state of Kansas.

Counseling, Testing, and Referral (CTR) Services

The Kansas CTR program provides both anonymous and confidential HIV counseling and testing with traditional technology (blood based EIA/Western Blot) by means of the 84 existing counseling and testing sites. Kansas Law requires that public HIV testing be available within 100 miles of each Kansas citizen however, at present, the program maintains testing within 75 miles of all Kansas citizens.

KDHE will utilize several strategies for improvement of efforts to identify newly infected persons. There are approximately 32 private sites for counseling and testing in high prevalence settings such as correctional facilities and drug treatment centers. For three years, OraSure® testing has been provided on an outreach basis to high-risk clients in 20 locations. The primary objective is to take testing into venues where the highest risk behaviors were taking place and to provide a testing opportunity to individuals in outreach locations. These venues include areas where individuals engage in intravenous drug use and anonymous public sex environments.

During 2002, traditional CTRS performed 11,423 tests for HIV. Of these , 35 (57 total) were unduplicated positive tests. The confidential testing rate in Kansas exceeds 90%. The post-test counseling rate for all tests is 82.6%. This compares to a 52% rate for the national HIV counseling and testing system in 1998. The Kansas HIV positive post-test counseling rate has been 100% since the inception of HIV reporting. This compares to a 62.5% for the national HIV counseling and testing system in 1998.

In 2002, the OraSure ® Pilot Project targeted outreach settings and partners of positive individuals and performed 1,102 tests. Of these, 9 (15 total positives 1.3%) were unduplicated positive tests. All tests were confidential and there was a 100% positive post-test counseling rate. All positive persons received partner counseling and referral services (PCRS). Based on the precedent established by the OraSure ® pilot program, KDHE will, in the near future, implement OraQuick ® testing for sites situated in higher volume and prevalence locations. Quality assurance guidelines have been developed and implementation is scheduled on a pilot test basis in January 2004.

The tracking of referrals into services for newly identified positive HIV cases is documented on the post-test positive checklist and the Ryan White II CARE case report. Newly identified positive cases are entered into the HARS database at that time. An alliance with KU Medical center and the use of the Quick Guide encourage and support routine referrals into care services. These items are supported by KDHE through initial counselor training and the publication of the Quick Guide.

In Wichita, a high prevalence area, newly infected persons are seen at the Kansas University Medical Center. Sites with newly infected persons can call there for an appointment and usually receive it the same day that results are provided to the client. They are also enrolled in case management and Ryan White II CARE services if applicable. The provision of positive results is usually performed with the assistance of a Disease Intervention Specialist (DIS) who offers partner counseling and referral services (PCRS) at the same time.

Twenty-one of the larger health department sites and a non-health department clinic are supported with additional funds to help defray the cost of counseling. All sites are provided free lab services and the use of DIS for post-test counseling and partner counseling and referral. Unfunded sites include health departments, community based organizations and other settings that express interest in providing counseling and testing services.

Partner Counseling and Referral Services (PCRS)

The overall goal of PCRS in Kansas is to provide partner counseling and referral to all newly diagnosed HIV and AIDS cases not previously diagnosed with HIV. This includes both public and non-health department settings.

The Disease Intervention Specialists (DIS) within the HIV/STD Section in Kansas are trained, motivated and evaluated in HIV prevention and intervention. DIS follow the HIV Partner Counseling and Referral Services Guidelines from CDC when performing counseling and referral services. HIV/STD Section Management is committed to interviewing all new HIV infections in Kansas and referring these clients into services. Additionally, management is committed to counseling and referring the client's partners into services. DIS have been interviewing HIV/AIDS cases in Kansas since the early 1990s. DIS provided approximately 20 interviews a year when there was only AIDS reporting.With the approval of HIV named reporting in July 1999 the number of interviews jumped to around 80 interviews per year. The large majority of HIV clients who are provided interviews are from private providers. Of the 115 interviews assigned to DIS in calendar year 2002, 77 % (88) were reported from private providers.

DIS in Kansas are fully trained in sexually transmitted diseases and HIV/AIDS. All DIS are required to learn all modules in the CDC STD Development Guide, make at least an 80 percent on tests following the modules and at least 80 percent on the comprehensive test for the entire STD Development Guide. Then training begins on the art of interviewing and investigating HIV/STD. This process starts with the successful completion of Introduction to STD Intervention (ISTDI), a two-week interview training course provided by a regional training site. Additionally, DIS are required to complete basic HIV counseling courses provided by the state. During this entire process new DIS are shadowing their peers and learning from real life interview and investigation situations. The total training process usually takes three to six months. The training process is strictly monitored and supervised by the Manager of Field Operations.

Kansas utilizes a continuous quality improvement based approach to all areas of the HIV/STD Program. The outcome oriented targets and objectives of the program reflect the processes involved in providing PCRS and feeds back into the system as an improvement loop.

Prevention for HIV-Infected Persons

Prevention Case Management (PCM) has been adopted in Kansas to promote and maintain risk-reduction behaviors and to bring partners of HIV-infected individuals into the health care system. Prevention case management is a service that is integrated into the regular Ryan White Case Management System for individuals infected with HIV. PCM is an enhancement of the mission of the existing case management system as opposed to a new and distinct activity with separate programmatic and funding requirements. Begun in 1999, PCM is a case management service under the Kansas Ryan White Title II CARE Program. The HIV/STD division of the Kansas Department of Health and Environment administers PCM under the Ryan White Title II CARE Program.

PCM is available to any client enrolled in the Ryan White Title II case Management system. Eligibility for prevention case management is based on the client's PCM acuity scale and risk assessment. All case managers are certified in HIV/AIDS case management, counseling, and testing. Services include risk assessment and the development of client-specific case plans, based on standardized tools that are assessed annually. Specific prevention activities include safer sex education, social skills training, self-esteem counseling, and substance abuse treatment. PCM relies on case managers as sources of referral for prevention services. PCM also serves as a potential access point for eligible partners and family members who are related to or affected by HIV-infected individuals already enrolled in the case

management system. Since 1999, nine HIV-positive partners of enrolled clients were identified through PCM, resulting links to HIV testing and were subsequently brought into the care system after receiving PCRS. This success illustrates the effectiveness of the continuum of prevention and care services in Kansas.

During 2002, a total of 776 PCM sessions were provided to HIV infected and affected clients. In 2002, the types of clients receiving PCM include HIV-infected clients, High-risk HIV-negative clients, and clients with Unknown Sero-status. Of the 776 PCM sessions provided, 523 PCM sessions were provided to HIV-infected clients; 224 PCM sessions were provided to High-risk HIV-negative clients; and 29 PCM sessions were provided to clients of Unknown Sero-status.

The Kansas Ryan White Title II Case Management Program, Prevention Services Manual, Prevention Case Management Standards of Practice will encompass resources and methods for all CDC interventions. The standards will serve as a guidance document for case management contractors performing PCM and prevention counseling services. Kansas is taking an integrated and pro-active course with this activity and intends, as a goal, to first illustrate that entering case management services itself can be correlated with a reduction in risk behaviors and second to illustrate that PCM integrated into case management as a targeted intensive intervention to those identified as most in need can have a positive impact on changing behaviors.

In providing structured PCM services for positives, case managers are able to provide clients with a wide spectrum of prevention services, including risk-reduction counseling, HIV education, and skill building. HIV prevention counseling is individual counseling provided by certified case managers to assist clients in assessing their personal risk for HIV, reinforcing previous attempts to change behavior, creating an appropriate, time-phased plan to reduce their risk, and enhancing the risk reduction skills the clients need to put the plan into action. Case managers are required to be certified in HIV counseling and testing, and they must be able to identify risk factors in clients. Moreover, certification of case managers is directly linked to training in HIV prevention. Specifically, case managers must complete certification requirements in HIV/STD Basic Training; Basic HIV Program: Fundamentals and Prevention Skills; Orasure Testing; Behavior Change Counseling Strategies; Cultural Diversity: Sexual Minorities and HIV Services; Cultural Diversity: populations of Color and HIV Services. These courses are the minimum requirements for case manager certification for Ryan White Title II Case Management and require successful completion to provide prevention services.

Case managers perform the functions of client intake, risk assessment, PCM acuity scale, case-plan development, case plan monitoring, reassessment, and discharge. The case plan includes access to HIV prevention services tailored to the specific needs, risks, and barriers identified by the case manager during assessment of the client. The provision of these linkages to prevention services is a specified requirement in the case management contracts. Clients are referred to PCM and prevention counseling through interactions between providers and case managers.

Upon implementation of the formalized PCM program, all clients enrolled in Kansas Ryan White Title II CARE Program have a PCM Acuity Scale completed within 6 months of November 2003. This will give the program adequate baseline data and determine eligible clients for PCM. The existing Ryan White case management acuity scale has 17 life areas, two of these life areas address knowledge of HIV and risk reduction. At this time, this data is insufficient to determine a client's eligibility for PCM. This data has assisted with addressing needs for HE/RR.

Targeted populations and/or clients for this intervention are HIV infected individuals and their partners. The focus will be emphasized on behaviors and not descriptors of various communities and/or groups. PCM services provided by Ryan White are intended for positives

who are having or who are likely to have difficulty initiating and sustaining safer sexual and drug use behaviors.

All contracted case management agencies will be required to secure a strong relationship with STD clinics, TB testing sites, substance abuse treatment programs, and other health service agencies. Case managers will be trained with the understanding that it is essential to have strong relationships with clinical care for successfully recruiting or referring clients who are at high risk or who are appropriate for this type of intervention. Case managers will receive training to recognize that PCM should be offered to both HIV-infected clients and their partners who continue to practice risky behaviors.

Contracted agencies will be required to establish formal and informal agreements (such as memoranda of understanding) with relevant service providers to ensure availability and access to key service referrals. A standardized written referral process for the PCM program must be established by each agency. Protocols for structuring relationships and communication between case managers and providers is required to avoid duplication of services. An example would be how to transfer or co-manage PCM clients with a substance abuse or mental health diagnosis. Policy and procedure regarding communication about an individual client between the case manager with other providers is dependent upon the obtainment of written, informed consent from the client. The case manager will be required to maintain a referral tracking system must be maintained. The case manager must perform an annual assessment of relevant clinical and primary medical care providers with current referral and access information. A mechanism to provide clients with emergency psychological or medical services must be established. Contracted agencies are responsible for developing a crisis intervention plan with appropriate provider contacts in place.

Case managers will be required to maintain an updated referral system consisting of the following services: substance abuse treatment, mental health counseling, STD diagnosis and treatment, women's health services, TB diagnosis and treatment, and other primary health care services. Contracted agencies will provide PCM services with the understanding that prevention services provided by case managers are not intended to be a substitute for extended social services, medical case management, or psychosocial care. Specific PCM services provided by case managers may include skills building, individual counseling, couples counseling, crisis management, resource procurement, and preparation for referral of partners. All assessed client needs for medical care will be referred to a medical provider, clinic, or hospital for appropriate treatment.

Health Education and Risk Reduction Services (HE/RR)

- Show evidence that their program focuses on populations, priorities and interventions determined by the HIV Prevention Plan and Community Planning Group. See Tables 1 and 2 for priority populations and interventions.

- Demonstrate that their Interventions are based on scientific theory consistent with the CDC Compendium of HIV Prevention Interventions and demonstrated evidence of effectiveness. See Table 2 for a list of interventions that will be funded for each priority target population.

- Are culturally relevant as indicated by the statewide Community Planning Group and conform to the norms and values of the intended population.

- Include a program evaluation plan that is in accordance with the KDHE Evaluation Plan.

- Participate in the KDHE administered statewide Web-based program evaluation system, requiring all grantees to report intervention specific data and target population/demographic information. Grantees are required to submit quarterly and end of year progress reports as well as on-going reporting of intervention activities.

Perinatal Transmission Prevention Activities

1) Provide voluntary HIV testing available to pregnant women at high risk for HIV infection.

1) Ensure that HIV-infected women and HIV-exposed infants have access to appropriate prevention interventions to reduce perinatal HIV transmission, and that HIV-infected women have access to appropriate treatment services.

Access to STD Diagnosis and treatment

A. Provide early detection and treatment of curable STD's by expanding screening and treatment programs for STDs in settings where the diseases are prevalent and populations congregate.

A. Collaborate and coordinate HIV and STD prevention programs to ensure STD's are diagnosed and referred for treatment by offering onsite, diagnostic services and referrals for treatment of other STDs.

School based efforts for youth

Provide school based programs that use the basic philosophy recommended by Buckingham, Doyen, and Main, 1995, are theoretically-based, adhere to sound instructional strategies and are recommended by students in the Kansas school system.

Provide prevention programs that allow youth to integrate what they have learned into their own experience, using real life situations and peers to model and reinforcer desired behaviors.

All programs should be skills-based and help to develop self-efficacy.

Evaluation of HIV Prevention Activities

A. Evaluate HIV prevention program activities, interventions and services.

Assess the quality of proposed interventions to make sure that they are scientifically sound, well organized and that the goals are clear and reasonable.

Conduct process evaluation of HIV prevention interventions for the purpose of prioritizing prevention efforts and improving the contractors ability to measure accomplishments in conducting prevention activities.

Conduct outcome monitoring of HE/RR individual and group level interventions for the purpose of measuring on-going behavior change in at-risk populations.

Gather and monitor information from contractors to ensure that targeted populations receive necessary services and/or are referred to other providers that will address the psycho social issues associated with high priority populations in Kansas.

B. Assess the implementation of HIV prevention community planning in Kansas.

Document the recruitment of community planning group members and representation of affected communities and areas of expertise on the CPG.

Verify the application of the needs assessment and an epidemiologic profile to prioritize target populations and strategies for HIV prevention activities and the application of scientific knowledge in the selection of prevention strategies.

Develop and monitor goals and measurable objectives for the community planning process and calculate the cost of the process.

Determine the extent to which the health department distributes resources to match the epidemiologic profile and conducts prevention activities which match the community planning group's recommendations.

HIV Prevention Technical Assistance Plan and Capacity Building

A. Assess the current and projected needs of service providers and the members of the CPG. Provide the necessary technical assistance and training that they have identified in order to build on their skills and knowledge.

Provide technical assistance to service providers and CPG members in the areas of grant writing, coalition building, behavioral science and theory based prevention activities, HIV prevention program planning, implementation, and evaluation.

B. Solicit and contract with agencies, workers, and volunteers who are representative of populations at high risk for HIV infection to conduct prevention activities.

C. Ensure that all HE/RR contractors 1) successfully complete the American Red Cross "Basic HIV/AIDS Program" including Fundamentals and Prevention Skills training; and 2) attend sensitivity training which includes issues of communities who are denied access to privileges and benefits based on skin color, gender, sexual orientation, economic circumstance, disability,

language and/or spiritual belief.

D. Strengthen the communication network between HIV prevention service providers and coordinate HIV prevention services and programs.

Develop and continue to make available an on-going statewide HIV prevention and care resource service directory.

In each region of the state, designate a contractor to serve as a regional HIV/AIDS resource coordinator for the purpose of strengthening communication, assistance, programing, and delivery of services.

Designate one contractor serving each CPG designated high priority target population to serve as a resource consultant for other service providers targeting that population.

KDHE provides technical assistance and training to contractors in the following areas: skills based training to counselors and persons providing HIV related services; basic HIV/AIDS counselor and education training (with co-trainers who are of color, and/or represent target groups at risk for infection); program planning, development, evaluation, grant writing, coalition building, capacity building; funding development, problem identification, and action planning. KDHE will continue to assess the technical assistance needs by comparing its prevention program with the needs of the communities at-risk, programs in similar rural states, and the latest prevention research and literature.

Collaboration, Coordination, and Linkage with Other Related Programs

Linkages between Primary and Secondary HIV Prevention Activities

The term “primary prevention” refers to preventing the transmission of HIV from one person to another. The term “secondary prevention” refers to preventing progression of HIV infection to severe immune-suppression, and preventing morbidity and mortality from opportunistic infections in persons already infected with HIV. “Linkage” between primary and secondary prevention refers to linkage between services for primary prevention and services for secondary prevention.

CPG recommendations for linking primary and secondary prevention services in counseling and testing sites includes 1) develop case management models that target HIV+ individuals and their sex partners for the purpose of teaching behavior modification techniques that decrease the risk of HIV transmission; 2) establish appropriate sources (used in the counseling process), to medical, care, social, and psychological services; 3) provide services to HIV infected individuals and their sex partners that encompass on-going health education and skills training for risk reduction; facilitate the development of peer-to-peer networking structures; provide and/or refer HIV+ individuals and their sex partners to counseling services as appropriate, assist consumers in making long term risk reduction behavior changes; and provide support and education regarding secondary infection. Services must be empowering, culturally, linguistically, age, and gender appropriate. The CPG recommended the development of an electronic and group network within HIV positive communities to provide information, enhance the sharing of knowledge, increase the visibility and decrease the alienation of individuals infected with the virus.

Linkages with HIV Prevention Related Activities

Set up networks and/or focus groups with communities to identify and assess continuing HIV prevention needs, and to disseminate the results of targeted prevention and community planning activities.

KDHE should promote the community planning process and make survey information, needs assessment results, recommendations, and the epidemiologic profile available to HIV prevention service providers and the public. An evaluation tool should be provided to KDHE contractors to assist them in developing, assessing, and disseminating the results of behavior change surveys for at-risk populations. HIV prevention activities should be integrated and liked with other disciplines such as drug treatment programs, STD treatment, and university-based research.

Coordination of HIV Prevention Services and Programs

To coordinate HIV prevention services and programs, contractors should set up networks and/or focus groups with community members, prevention counselors, educators, and care providers for the purpose of identifying and assessing continuing HIV prevention needs, information sharing and other related issues. KDHE should designate a funded contractor to serve as a Regional HIV/AIDS Resource Coordinator for the purpose of strengthening the communication network between service providers in each HIV Case Management region. Additionally, a funded contractor for each high priority target population should serve as a resource consultant, provide skills training, educational materials development, and establish a statewide network for HIV prevention contractors and other organizations serving each targeted population. HIV prevention counselor and educator training session should be coordinated with other co-sponsors.

APPENDIX 1

CPG BY-LAWS

KANSAS HIV PREVENTION COMMUNITY PLANNING GROUP BY-LAWS

ARTICLE I - NAME

The name shall be the Kansas HIV Prevention Community Planning Group; subsequently known as the CPG

ARTICLE II - MISSION STATEMENT

To develop an on-going, comprehensive HIV prevention plan for Kansas that is responsive to community identified needs.

ARTICLE III - MEMBERSHIP

Section I Initial planning group members were solicited through nominations at the January, 1994 Kansas AIDS Networking Project (KANP) and through the state.

Section II The initial planning group members (steering committee) were:

Ambrosio, Jeanine (C)	State - AIDS Section
Belk, Nadine	State - Corrections
Bell, Ray	CBO - Topeka AIDS Project
Bullocks, Jimmy L., Sr.	CBO - Stardusters
Carter, Jean	At Large - HOPE /Wichita AIDS
Christopher, Joshua (C)	At Large
Donner, Kathy	State - Alcohol & Drug Abuse
GoodPankratz, Gretchen	CBO - WeKare
Grosko, Joyce	State - Board of Education
Heter, Charles	CBO - Harvest America
Patton, Cody	AIDS Coordination Team
Stehly, Carol	LHD - Johnson Co. Health Dept
Zillinger, Margaret	State - Medical Services

Section III The CPG will consist of up to twenty-five (25) members. This group shall reflect the diversity of the community. Recruitment shall be guided by the principles of inclusiveness, representation, and parity as established by CDC in Section 1.3.2.1, CDC Criteria, Handbook for HIV Prevention Community Planning. (SEE ADDENDUM A).

Section IV A minimum of 3 positions will be filled by individuals with HIV infection. As many as two persons who meet the other criteria of the Recruitment Committee may be elected as alternates for any position filled by an individual with HIV infection.

Section V No more than 4 positions will be filled by representatives of state agencies.

ARTICLE IV - TERMS OF MEMBERSHIP

Section I All non-state representative members shall serve for a period of two years beginning with the month of their election to the Community Planning Group. This two year period shall be considered one term. (SEE ADDENDUM B).

Section II Nominees completing the Review Process under the direction of the Recruitment Committee shall be presented to the CPG for election. The KDHE Co-Chair may conduct a telephone poll seeking concurrence on the nomination. However, election must be confirmed by a roll call vote of the CPG at the next scheduled meeting attended by the nominee.

Section III Any member may nominate themselves for a second term on the CPG. At the end of the second term of two years, members may nominate themselves for additional one year terms without limit. All nominees will be subjected to the CPG Review Process developed by the Recruitment Committee. (SEE ADDENDUM C)

Section IV Four state-wide agencies are designated for indefinite representation on the CPG by the Kansas Department of Health and Environment (KDHE). The state-wide agencies represented are:

- The Kansas Department of Health and Environment (KDHE)
- The Kansas Department of Corrections (DOC)
- The Kansas Department of Education (KDE)
- The Kansas Alcohol and Drug Abuse Services (ADAS)

For the purposes of this document, these agencies will be referred to as state agencies from this point forward.

ARTICLE V - VACANCIES

Section I All vacancies will be subject to the guidelines developed in the Selection Criteria, created by the Recruitment Committee. (SEE ADDENDUM D)

Section II An open nomination process will be used to fill all vacancies.

Section III If a vacancy is created before the expiration of a non-state member's term of service, the person who fills that vacated position will begin serving a two year term at the next scheduled meeting attended or participated in by the nominee. This will be considered the individual's first two-year term of service.

Section IV All vacancies occurring after December 31, 1994, with the exception of the four designated state agencies, will be subject to the CPG Review Process developed by the Recruitment Committee. (SEE ADDENDUM C)

Section V Should a state representative vacate their position, the Director of the KDHE HIV/AIDS Section will contact the state agency to request a replacement representative be assigned to the committee.

Section VI Should a state agency vacate their position on the CPG, the Director of the KDHE AIDS Section, will contact an appropriate state agency (as determined by the CPG and KDHE) to request a replacement representative be assigned to the committee.

ARTICLE VI - OFFICERS, ELECTION AND DUTIES

Section I The officers of the Community Planning group shall be two Co-Chairs, a Co-Chair Designate and a Recorder. One of the two Co-Chairs shall be the HIV Community Planning Consultant employed by KDHE, hereafter referred to as the KDHE Co-Chair. The other Co-Chair shall be known as the Community Co-Chair. Officers with the exception of the KDHE Co-Chair, shall be selected from among those members of the Community Planning Group who are not State officials.

Section II The Community Co-Chair, the Co-Chair Designate and the Recorder shall be elected by a majority vote of the entire membership. These officers shall be elected to serve a one year term at the first meeting of each calendar year or the next meeting following a vacancy. Persons shall assume the responsibility of office immediately following election. The Co-Chair Designate serves in that capacity for one year following which s/he serves as the Community Co-Chair for one year.

Section III At least thirty (30) days prior to the meeting designated for the election of officers, the Chair of the Recruitment Committee will ensure that requests for nominations for all offices be mailed to all voting members of the Community Planning Group. During the meeting designated for election of officers, the Recruitment Committee shall present a ballot of the nominated candidates to the membership.

Section IV Duties of the Community Co-Chair. The Community Co-Chair shall preside at meetings; shall develop the agenda for meetings along with the KDHE Co-Chair, and shall act as Chair of the Executive Committee. The Community Co-Chair shall involve the Co-Chair Designate in meetings, planning and leadership.

Section V Duties of the KDHE Co-Chair. The KDHE Co-Chair shall work with the Recorder on the minutes and reports; shall counsel and support the committees of the CPG; shall keep in regular contact with CPG members; and shall be responsible for process progression according to the needs of KDHE.

Section VI Duties of the Recorder. The Recorder shall be the custodian of the minute books of the CPG; shall be responsible for the accurate keeping of the minutes of all meetings of the group; work with the KDHE co-Chair on the perfection and distribution of the minutes; shall keep a list of all committees and their membership; and shall keep a record of attendance at all CPG meetings.

Section VII Co-Chair Designate. This elected official is the next Community Co-Chair.

The responsibilities of office are limited, but this person should be included in conversations between the Co-Chairs and kept current on the responsibilities and activities of the CPG. In the absence of the Community Co-Chair, the Co-Chair Designate shall carry out the tasks of the Community Co-Chair.

ARTICLE VII - COMMITTEES OF THE GROUP

The Community Planning Group shall have exclusive power and authority to manage the affairs of the organization, provided, however, that the Group may delegate all or a portion of its functions from time to time to committees consisting of such individuals as are designated by the CPG. The CPG shall retain the authority to have final approval of all action taken by each committee.

Section I The Executive Committee may act in place and stead of the CPG between meetings of the CPG on all matters, except those specifically reserved by the CPG by these By-Laws, pursuant to delegation of authority to such committee by the CPG. The Executive Committee shall be made up of the chairperson from each small committee, the Community Co-Chair and the KDHE Co-Chair. Attendance from seventy-five percent (75%) of the Executive Committee members are required for a quorum. The Community Co-Chair shall be the only one to call meetings of the Executive Committee. Actions of the Executive Committee shall be reported to the members of the CPG for ratification by mail or at the next CPG meeting. This committee shall be subject to the orders of the CPG and none of its acts shall conflict with actions taken by the CPG. The Executive Committee shall advise the Community Co-Chair on the recommendations of small committee assignments.

Section II The following is a list of the standing committees of the CPG:

- Evaluation
- Programs & Strategies
- Recruitment
- By-Laws

Section III Each Committee shall have a chair elected by the committee, or if a committee cannot elect a chair, a chair shall be appointed by the Community Co-Chair of the CPG.

Section IV Core membership from the CPG on each standing committee shall be as representative as possible. The Recruitment Committee has the authority to reassign members if representation cannot be achieved voluntarily. Any member of the CPG can be a part of any standing committee meeting, regardless of which committee they normally have membership.

Section V All committee meetings will be governed by the same set of rules as established in ARTICLE VII - MEETINGS AND ARTICLE VIII - ATTENDANCE.

Section VI The CPG can create, delete, and/or rename committees.

ARTICLE VIII - MEETINGS

Section I All meetings shall be open to the general public and follow a written agenda. Requests for inclusion of a specific item to the agenda should be made no later than seventy-two (72) hours prior to any scheduled meeting. Written minutes shall be provided to all CPG members prior to subsequent meetings.

Section II The CPG shall follow a general open meeting format with specific structure to be determined by Co-Chairs.

Section III All decisions of the CPG shall be made by consensus. Consensus shall be defined as all members willing to support and "sign-off" on decisions.

Section IV If consensus is not possible, the decision of the CPG shall be made by vote.

Section V Any CPG member may call for a vote if consensus is not reached. Vote must be passed by 2/3 of members present.

Section VI In order to vote, CPG members must be present. PLWA members are exempt from this rule.

Section VII Only CPG members shall be allowed to participate at meetings, unless the Co-Chairs have made a decision to plan requests on the meeting agenda.

Section VIII An open forum will be held at the end of each meeting. Any individual may call a Co-Chair to request to speak at the open forum. They will be assigned a date and time with a five-minute presentation limit.

Section IX Written notice of the time and place of all CPG meetings shall be given to committee members. Regular meetings are scheduled for the first Wednesday of the month.

Section X When community forums are held, notice will be given through various media, including, but not limited to, newspaper, announcements in community centers, posters, public bulletin boards, etc.

ARTICLE IX - ATTENDANCE

Section I All CPG members will be allowed two (2) un-excused absences in a 12 month calendar period running from January to December each year. An excused absence from a CPG meeting is defined as notification to one of the two Co-Chairs (KDHE or Community), prior to the beginning of any regularly scheduled meeting. An excused absence from a committee meeting is defined as prior notification to the chair of the committee or the KDHE Co-Chair.

Section II If a member has more than two (2) un-excused absences within a twelve month calendar period, the Recorder shall inform the Community Co-Chair. The Community Co-Chair will write to the member, informing them of their

attendance record. In that written communication, the Community Co-Chair will request that the member make written response within two weeks indicating whether the member wishes to continue on the CPG and what might have changed in their situation that will allow them to attend meetings in future months. The member's response to this request will be reported at the next meeting of the CPG. If there is no response, if the member does not wish to continue, or there are no changes in personal circumstance, the CPG may vote to remove the member from the CPG. If there is such a vote, the Recruitment Committee will be advised to solicit for a replacement.

Section III If a member misses fifty percent (50%), either excused or un-excused, of Community Planning Group meetings within a 12 month calendar period, the Recorder shall inform the Community Co-Chair. The Community Co-Chair will write to the member, informing them of their attendance record. In that written communication, the Community Co-Chair will request that the member make written response within two weeks indicating whether the member wishes to continue on the CPG and what might have changed in their situation that will them to attend meetings in future months. The member's response to this request will be reported at the next meeting of the CPG. If there is no response, if the member does not wish to continue, or there are no changes in personal circumstances, the CPG may vote to remove the member from the CPG. If there is such a vote, the Recruitment Committee will be advised to solicit for a replacement.

ARTICLE X - ADMINISTRATION

Section I All CPG members shall be provided a current edition of CPG's By-Laws. A signed statement of receipt of those By-Laws shall be kept on file. (ADDENDUM E)

Section II All CPG members shall be required to sign a Job Description Statement and a Disclosure Statement during his/her orientation to CPG. (ADDENDUM B & F)

ARTICLE XI - CONFLICT OF INTEREST

Section I In making recommendations to the Department of Health and Environment concerning priorities, the planning group must operate in compliance with all applicable state and local conflict of interest laws. In order to safeguard the planning group's recommendations from potential conflict of interest, each member shall disclose any and all professional, and/or personal affiliations with agencies that may pursue funding. A Disclosure Statement form will be completed by each group member and kept on file. On issues where a group member's affiliate is the potential recipient of funds, that member may not vote on that issue.

Section II The administrative agency (KDHE) shall develop and publish a policy and procedures regarding conflict of interest. Said policy and procedures shall be developed in order to safeguard the Committee's recommendations and actions from potential conflict of interest. Each member shall disclose any and all professional and/or personal affiliations with agencies that may pursue funding. On issues where a Committee member's affiliate is the

potential recipient of funds, that committee member may not vote on that issue.

Section III During his/her orientation to CPG, each member shall disclose in writing any and all professional client or personal affiliations with agencies that may pursue HIV prevention funding. A Disclosure Statement form shall be completed annually at the first meeting of each calendar year, on or before June 15th, and kept on file.

ARTICLE XII - CONFLICT RESOLUTION

Section I In the event of disagreements and/or differences which cannot be resolved through discussion and other By-Law procedures, do not bring resolution, the CPG may vote to seek the help of an outside mediator.

Section II The CPG will use the services provided by the current agency contracted with through the Centers of Disease control and Prevention who will attempt to arbitrate the matter.

Section III Should it be impossible to resolve the issue(s) in this manner, a person from the contracted agency in Section II will make a binding decision.

ARTICLE XIII - PARITY AND TRAINING

Section I All new members elected to the CPG will be given a Handbook which will contain, but not be limited to: the past 12-months minutes of the CPG meetings; the By-Laws; the current HIV Prevention Strategic Plan, supplemental applications, and EPIDEMIOLOGICAL profile; the *Orientation Guide* developed by the Academy for Educational Development (AED), and *Positive Input* developed by National Association of Persons Living With AIDS (NAPWA). This package will be developed by KDHE staff as directed by the By-Law Committee.

Section II Each new member would be assigned a mentor from the current membership on the CPG. Mentors would be listed first by tenure, and then by alphabetical order. The Co-Chairs of the CPG would be excluded from this list.

Section III After the meeting of the CPG when a new member is elected and before the next scheduled meeting, the Co-Chair(s) and mentors, or community members, will hold an orientation meeting with the new member(s). The presentations during this meeting are primarily the work of the Co-Chairs and the purpose is to bring the new member(s) up to the current stage of the work being done by the CPG. At this meeting, and at least before the next CPG meeting, a new member will select on which of the five committees they will serve. This information will be given to the mentor and then communicated to the Community Co-Chair.

Section IV The expectations of the mentor are a) to attend the orientation; b) to be available to the new member for information and counsel for six months; and c) to contact the Community Co-Chair with information on what small committee the new member selected to serve.

ARTICLE XIV - REIMBURSEMENT

Section I All non-state representative on the statewide CPG are considered consultants to KDHE. CPG consultants will be compensated for their services at the rate of $75.00 per day for each scheduled CPG meeting.

In addition, all non-state representatives will be reimbursed for mileage at the state reimbursement rate for each schedule CPG meeting and mileage (when appropriate) for each scheduled small committee meeting.

In addition, all non-state representatives will be reimbursed for lodging expenses necessary to attend each scheduled CPG meeting and each scheduled small committee meeting with this one condition, that prior approval be given by the Executive Committee for lodging at the state reimbursement rate.

Section II Compensation for CPG consultant fees shall not exceed a total of $1,999.99 in any given state fiscal year, July 1 through June 30.

ARTICLE XV - PARLIAMENTARY AUTHORITY

Section I The rules continued in the current edition of Robert's Rules of Order, Newly Revised, shall govern in all cases to which they are applicable and in which they are not inconsistent with these By-Laws and any operating procedures previously adopted by the CPG.

ARTICLE XVI - MODIFICATION OF BY-LAWS

Section I These by-laws may be changed and/or amended by a vote of two-thirds (2/3) of the members of the CPG.

ADDENDUM A

Section I.3.2.1. CDC Criteria

Members should:

1. Reflect the characteristics of the epidemic in terms of current AIDS cases, persons with HIV infection, and those at highest risk for HIV/AIDS. Criteria such as age, race/ethnicity, gender, sexual orientation, geographic distribution, HIV exposure status and category will be used as selection criteria.

2. Be able to articulate and have expertise in understanding and addressing the specific HIV prevention needs of the populations they represent.

3. Include scientific experts; service providers; representatives of organizations, such as state and local health departments and education agencies; other relevant governmental agencies (substance abuse, mental health, corrections); experts in epidemiology, behavioral and social sciences, evaluation research, and health planning representatives providing HIV prevention and related services.

ADDENDUM B

Job Description
Statewide HIV Prevention Community Planning Group Member

The following job description is provided to give you an idea about the role and responsibilities of group members of the Statewide HIV Prevention Community Planning Group. Please read the description and sign below if you agree to serve in this capacity on the group.

A. Role Statement

As a member of the Kansas Statewide HIV Prevention Community Planning Group, it is your role to make a commitment to the process and its results by:

1) Participating in all decisions and problem solving
2) Undertaking special tasks, as requested by the Planning Group
3) Gathering data and information as needed.

B. Length of Commitment

All terms for Planning Group members not representing State agencies will be for two years.

Participation by Planning Group members representing State agencies is for an indefinite term, unless specified otherwise by the appointing authorities for those agencies.

C. Estimated Time Required

Monthly meeting and/or teleconference meetings of one to nine hours each, plus special meetings called when needed. Possible additional meetings of ad hoc committees. Up to eight hours per month for specific task completion.

D. Major Duties and Tasks from Supplemental Guidance, Section H

1. Delineate technical assistance/capacity development needs for effective community participation in the planning process.

2. Review available epidemiologic, evaluation, behavioral and social science, cost effectiveness, and needs assessment data and other information required to prioritize HIV prevention needs and collaborate with the AIDS Section of KDHE on how best to obtain additional data and information.

3. Assess existing community resources to determine the community's capability to respond to the HIV epidemic.

4. Identify unmet HIV prevention needs within defined populations.

5. Prioritize HIV prevention needs by target populations and proposed high priority

strategies and interventions.

6. Identify the technical assistance needs of community-based providers n the areas of program planning, intervention, and evaluation.

7. Consider how the following are addressed with the Comprehensive HIV Prevention Plan:
    - Counseling, testing, referral, and partner notification (CTRPN), early intervention, primary care, and other HIV related services;
    - STD, TB, and substance abuse prevention treatment;
    - Mental health services; and
    - Other public health needs.

8. Develop goals and measurable objectives for HIV prevention strategies and interventions in defined target populations.

9. Evaluate the HIV Prevention Community Planning process and assess the responsiveness and effectiveness of the AIDS Section's application for federal HIV prevention funds in addressing the priorities identified in the Comprehensive HIV Prevention Plan.

I have read the job description and am prepared to make a commitment to this HIV Prevention Community Planning process and its results.

_____ _____

Name Date

ADDENDUM C REVIEW PROCESS

This criteria has been developed by the Recruitment Committee to ensure that an open and fair mechanism is created which allows for the identification, nomination and selection of participants to the Community Planning Group.

1. ENSURE FOR INCLUSIVENESS AND REPRESENTATION

A. Compare the results of the CPG Inclusion/Representation Survey (required of all serving CPG members) to the current Epidemiological Profile for the State of Kansas. Identify non-represented individuals or organizations, using the guidelines established by CDC in Section 1.3.2.1 CDC Handbook for HIV Prevention Community Planning (Article III, Section III of the CPG By-Laws).

B. Undertake recruitment efforts that assure identified target populations who represent at-risk groups are informed and included in the nomination process. This can include advertising in publications which serve target populations, public announcements, recruitment from key sources such as CBO's, meetings, well known spokespersons or agencies, etc.

2. ASSESS CANDIDATES FOR MEMBERSHIP USING DEVELOPED ASSESSMENT STANDARDS SO THAT THE MOST APPROPRIATE INDIVIDUALS ARE SELECTED.

A. Distribute completed nomination forms to all Recruitment Committee members for the purpose of "scoring" the candidates. Selection criteria developed by the Recruitment Committee must be used to score the candidates.

B. Discuss and compare scores for the purpose of selecting the most qualified candidates to be interviewed. Consideration must be given to the level and type of experience and the resources that each nominee can bring to the planning group.

C. Interview candidates with standardized interview questions. These questions must be developed to help identify candidates who can best meet the current needs of the CPG as identified by the Recruitment Committee in accordance with the CPG By-Laws and the Review Process guidelines.

D. Using the guidelines developed by the Recruitment Committee for selection criteria (See Addendum D), review and discuss qualifications of appropriate candidate(s). Recommend selected candidates to the CPG for approval.

3. NOTIFY CANDIDATES APPROVED BY THE CPG OF THEIR SELECTION

4. ENCOURAGE INDIVIDUALS WHO WERE NOT SELECTED TO PARTICIPATE AS A COMMUNITY CONTRIBUTOR.

ADDENDUM D

For Interview Purposes
Inclusion/Representation Selection Criteria

To establish an objective, uniform and equitable review process, the following selection criteria were developed by the Recruitment Committee to serve as the basis for rating each nominee.

1. The ability to make a time commitment to be a full participant and have a willingness to undertake special tasks as assigned by the CPG group.

2. The ability and desire to be a team player, which includes being able to provide constructive feedback.

3. The ability to keep key organizations and/or communities informed of the HIV Prevention Community Planning Group's work.

4. The ability to bring representation, yet be flexible and mature enough to focus on the overall plan, to see the "big picture."

5. Expertise in HIV prevention/education.

6. Is a member of a target and/or under served group(s) represented in the state epidemiological profile or speaks for, is a part of, works with, and has expertise in understanding and addressing the specific HIV prevention needs of a community represented in the state epidemiological profile. (Individuals who are members of target and/or under served group(s) will be given extra consideration.)

Each criteria will be given 10 points for a total of 60 points. Using the criteria established above, the members of the Inclusion/Representation Subcommittee will assign a score to all applicants after the interview process is completed.

In addition to the selection criteria mentioned above, other factors such as the need to ensure diversity and parity will also be considered.

ADDENDUM E

Receipt of By-Laws

I have received a copy of the HIV Prevention Community Planning Group By-Laws.

Signed: _____

Date: _____

ADDENDUM F

DISCLOSURE FORM

The State Wide Community Planning Group of Kansas
Conflict of Interest Disclosure Form

The State Wide Community Planning Group of Kansas has members who are professionally or personally affiliated with organizations that have, or may request or receive funds for HIV prevention activities. Because of the potential for conflict of interest, this Disclosure Form has been adopted by the State Wide Community Planning Group of Kansas and must be completed by all current and future group members.

By my signature below, I certify that:

1) I have read, understand, and support State Wide Community Planning Group's "Conflict of Interest" By-Laws.

1) I and/or a family member am/are (has/have been) within the past twelve months, serv(d) in a staff, consultant, officer, board member, or advisor capacity with the following organization(s) that has/have received, may seek or is/are eligible for funding HIV prevention activities. (Please attach additional pages if necessary)

Organization:_____

Title: _____ Period of Affiliation:_____

Organization:_____

Title: _____ Period of Affiliation:_____

Organization:_____

Title: _____ Period of Affiliation:_____

Group
Member:_____

Signature:_____

Date of Signature: _____

Date Form Received by CPG: _____

APPENDIX 2

2002 HIV/AIDS EPIDEMIOLOGIC PROFILE

http://www.kdhe.state.ks.us/hiv-std/download/epiprofile.pdf

APPENDIX 3

COMMUNITY SERVICES ASSESSMENT

http://www.kdhe.state.ks.us/hiv-std/download/needs_assess.pdf

Kansas HIV/AIDS Community Planning Group Strategic Plan

APPENDIX 4

EVALUATION PLAN

APPENDIX 5

PROVEN EFFECTIVENESS OF INTERVENTIONS

RATIONALE FOR RECOMMENDATIONS

HIV Counseling, Testing, Referral, and Partner Notification (CTRPN)

Counseling and Testing

Counseling and testing provides a personalized, client-centered encounter in which an individual can learn his/her serostatus as well as obtain tools to assess his/her own risk. Counseling can also help clients develop personal methods for behavior change that decrease risk for HIV and helps in maintaining a low risk status. Clients can also receive referrals and information relevant to their needs as well as assistance in notifying partners.

Counseling and testing services can motivate individuals to recognize their risk, ask questions about safer sex in a safe environment, and formulate personal risk reduction plans. Counseling and testing programs also allow prevention providers to identify new target populations.

Demonstrated Effectiveness

The effectiveness of HIV counseling and testing on behavior change has been examined for several populations, mainly to inform the debate about the value of public and privately supported wide-scale testing programs. Higgins et al. (1991) compiled and compared to a group of studies examining the impact of counseling and testing of various population groups. Her findings support the assertion that while HIV counseling and testing programs are important, they should not necessarily be the center of HIV prevention efforts. Most of the studies cited in Higgins's report do not examine the effect of counseling, but, rather, examine the effect of HIV testing or knowledge of serostatus. Many of the studies make no reference to whether the individuals received any counseling, or if they did, to what extent. A more thorough examination of the studies cited reveals that even those studies that did provide counseling vary from viewing a video to a didactic lecture format to extensive counseling. When studies are viewed in this context, it appears that when HIV counseling and testing affects behavior change, it is because it is provided in a manner consistent with the recommendations provided by the Centers for Disease Control on "appropriate" counseling.

In a more recent review of the literature on prevention programs, Choi and Coates (1994) come to conclusions similar to those of Higgins. They conclude that HIV counseling and testing have a place in HIV risk reduction, but are not sufficient for HIV reduction. HIV counseling and testing do not have impact on certain behaviors in certain populations. For example, HIV counseling and testing is associated with lowering sexual risk behavior among homosexual men, and injecting drug use among IDU. HIV counseling and testing with couples is associated with reductions in transmission among sero discordant couples. However, HIV counseling and testing has not had an impact on pregnancy decisions among seropositive women, and only modest effects were demonstrated with STD clinic patients.

A study of women at community health clinics in Connecticut found limited effects of HIV counseling and testing on subjects' risk behaviors and psychological functioning related to HIV. While there appeared to be no change in sexual behavior among women who were tested, there was a decrease in intrusive thoughts around HIV (Ickovics et al., 1994). Erhardt's (1995) review of effectiveness studies of counseling and testing and other individual counseling interventions targeting women, found it difficult to be conclusive about the impact of these interventions on women.

In a study of gay males in bars in small cities, HIV risk behavior was examined as it related to

HIV antibody testing practices (Roffman et al., 1995). Researcher found that men who had been tested tended to be more sexually active, more likely to have sex with multiple partners, and engaged in more protected and low-risk sexual activities than men who were not tested. The authors offered two explanations for this: 1) men who have been tested, rather than reducing sexual activity as a means of avoiding risk, choose to adopt protective behaviors when engaging in higher risk activities; and 2) these men may also be "more likely to make distinctions about the contexts for anal intercourse with which condom use is either necessary or unnecessary (e.g., with a long term partner who is HIV negative). From this, the study authors concluded that increased safer sex practices were associated with HIV antibody testing at both the community and individual level. The implications of these findings, as proposed by the authors, is that HIV testing should be made more available to this population and policies should be established to encourage test-seeking.

All cognitive and learning based theories have an informational component. People need information on HIV/AIDS transmission and prevention. Counseling provides valuable information to raise awareness for a need to change, and can alter the beliefs, attitudes, and/or intentions that influence behavior (social cognitive theory). According to more complex theories of behavior change, and empirical data, information is necessary but insufficient in producing sustained behavior change. Individuals must have the skills and the beliefs (self-efficacy) that they can carry out the preventive behaviors. Referral of both seropositive and sero negative individuals to other sources for continued support, education, counseling, and risk reduction skills training should be emphasized, given that research shows information alone is not enough to sustain behavior change.

Suggested Uses

Counseling Testing Referral (CTR) is universally applicable, although different groups may be reached through anonymous and confidential testing or through different testing venues. Anonymous testing serves the needs of clients who fear the repercussions of reporting of their HIV status, or who simply do not want their name on record. Confidential services expand the possibilities for follow-up and case management of the testing client. With youth and pregnant women, it may make more sense to focus on confidential testing and the capability for referral to services.

There is some debate over the most appropriate environment for CTR (e.g., a site created just for HIV CTR or a primary care facility) and the most appropriate kind of provider (e.g., a primary care physician -doctor or nurse - or an HIV testing counselor). The primary care context may be more appropriate for communities in which there is more stigma attached to HIV and/or a greater likelihood that people will seek care from a single provider and for general health concerns. It is important, however, to ensure that doctors or nurses providing test results are fully trained to do the counseling and referral work for their clients. Training of all CTR providers should be ongoing and central to the program. CTR can function as a method of HIV prevention; it becomes part of a regimen of health care. CTR may have fewer benefits for people in a situation of total isolation and lack of social support. It may have fewer benefits for people in an early stage of recovery from substance abuse, although CTR can become part of the recovery program if it is done properly and/or the client responds well.

Partner Notification (PN)

Partner notification is a traditional disease control intervention used in fighting sexually transmitted diseases. It involves public health officials taking responsibility for locating and notifying the sexual and needle sharing partners of people who have tested positive for HIV. Voluntary partner notification and counseling should be offered to every individual who tests

positive for HIV infection at a publicly funded testing site and in a comprehensive manner to all private providers reporting a new infection. Each HIV positive individual and private provider reporting a new HIV infection should also be offered information regarding referral services to local care providers and Ryan White case management services. The choice to participate in the process must reside with the patient provider and the client.

Documented Effectiveness

Several researchers have conducted evaluations of partner notification programs. A study of partner notification in North Carolina found that provider-referred notification was more successful than the patient-referral method. Half of the provider-referral group were notified compared to only 7% of the patient referral group. The study was limited by the large number of tested individuals who declined to participate. The authors also note that the effectiveness of partner notification can be limited by those who test positive and do not return for their results (Landis et al., 1992).

A retrospective analysis of partner notification services in Colorado found that patients referred only 20% of eligible partners compared to 71% referred by the provider. Heterosexual men referred a greater proportion of partners through patient referral than did gay men. The proportion of patient referrals among white patients was higher than that of Latino and African American patients (Spencer et al., 1993).

In a different Colorado study, Hoffman et al. (1995) compared the effectiveness of partner notification services of an anonymous test site with those of confidential test sites. The researchers found that confidential test sites were 30 to 50% more likely to have notified and counseled the partners of HIV-positive clients. While there was no tracking of the ATS clients' rate of partner notification on their own, the authors cite other research that found that patient-referral partner notification was less effective than provider-referral notification.

Suggested Uses

Partner notification is generally applicable for anyone wishing to inform partners of their positive HIV status, often it may be the only means by which people who are at risk as partners become informed of their risk. Partner notification is especially valuable for anyone who wishes to notify a partner who is not currently in their life or who may have a violent or abusive reaction to hearing the news from the client. The intervention can be done by the service provider alone, or can be done jointly by the service provider and the client, depending on what is more comfortable and safe for the client. Partner notification is always an in-person service, allowing for on-the-spot counseling and referrals.

Health Education and Risk Reduction (HE/RR)

Health Education and Risk Reduction

The goals of health education and risk reduction activities are to provide information, education, and counseling that assists individuals in developing the skills, abilities, and self-esteem to carry out behavior change (CDC, 1995). Health education and risk reduction interventions can be delivered at individual, group, community, or outreach levels. HE/RR activities can include counseling, workshops, educational programs and materials, presentations, and outreach activities.

Rinck and associate (1995) established the need for education and risk reduction strategies in the Kansas Needs Assessment. First, counseling and testing services, which include the provision of information, were clearly not sufficient to change and maintain risk reduction strategies among gay, bisexual, and MSM respondents. Next, based on consumer feedback, the authors recommended more and expanded education on HIV transmission, more effective risk counseling, and counseling and workshops on decision making, skill building, communication, alternative methods, and sexuality. Consumers suggested follow-up training and condom and needle distribution in street outreach programs as strategies to improve prevention. Risk reduction strategies are needed in various areas. For example, research by Peterson and colleagues (1992) exemplifies the literature on barriers to condom use. The authors cite condom norms, condom efficacy, and negative expectations about using condoms as reasons for non use. They conclude that risk reduction interventions should build skills to eroticize condoms and encourage their use. Social cognitive theory (Bandura, 1994) states that for individuals to institute behavior changes, they must believe they have the skills, and are capable of initiating and sustaining the actions necessary to implement the desired changes (self-efficacy). Self-efficacy is malleable, and skills training in risk reduction behaviors can change perceived self-efficacy (Bandura, 1994; Valdiserri et al. 1992) and enhance the adoption of risk-reduction strategies.

In an outreach intervention in which community health workers provided AIDS education and substance abuse treatment referrals and distributed bleach bottles, Watttersers and associates (Wattersers, Downing, Case, Lorvick, Cheng & Ferguson, 1990) reported significant increases in needle cleaning and condom use and reductions in needle sharing. Choi and Coates (1994), reporting on a study by Weibel and colleagues over a four year period, noted a substantial reduction in needle sharing among IDUs after a peer-outreach program was conducted. Finally, a multi-city street outreach intervention, the National AIDS Demonstration Research Program, designed to deliver HIV risk reduction messages and promote participation in HIV prevention services, yielded a large reduction of needle sharing and an increase in condom usage (Stephens, Simpson, Coyle, McCoy, & the National AIDS Research Consortium, 1993).

Individual-level Counseling

Individual-level counseling is one-on-one, peer intervention involving a wide range of skills, information, and support. Individual-level counseling, or prevention case management, is an intensive, individualized support intervention designed to assist persons at high risk for or infected with HIV to either remain sero negative or to reduce their risk of transmission to others. Prevention case management offers services in a repeated, intensive manner in order to promote and support on-going safer behavior.

Demonstrated Effectiveness

Personal efficacy, one of the strongest predictors of low sexual risk-taking, can be built through prevention case management (Stall, Coates, & Hoff, 1988). Although there are no formal evaluations of prevention case management as an intervention, there are many reasons to believe that it could act as an effective strategy. Extensive evidence supports, for example, comprehensive and intensive prevention programs and prevention case management are able to assist an individual to address all of the potential risk factors that can lead to unsafe behavior.

Group-level Counseling

Group level interventions shift the delivery of services from the individual to groups of varying sizes. Group-level counseling uses peer or non-peer models involving a wide range of skills,

information, and support.

Single Session Group Workshops

A single session group workshop consists of a one-time, intensive session or gathering focusing on information about HIV (e.g., transmission and behavior change), motivational activities, and skill-building. It may also touch on other relevant issues. This intervention can take a variety of forms, such as involving impromptu groups, using vans as session sites, and before/after bar groups. The specific intervention is planned or requested, usually based on advertising or promotion of the availability of the service.

Documented Effectiveness

According to service providers, multi-session group interventions have a greater impact on participants than single-session interventions. Providers note, however, that single-session interventions are also effective and give access to members of target populations who would not attend multi-session programs. Group interventions are more effective when they address other social or personal issues such as racism, domestic violence, or poverty. There are many studies evaluating the effectiveness of group presentations as an HIV prevention strategy. Presentations that emphasize skills for behavior change and that are more interactive are more effective than those that simply rely on the didactic transfer of information. The effectiveness of the didactic transfer method for information is still uncertain. Some studies say it does affect behavior, while others claim that it does not. It is safe to say, however, that basic information on HIV transmission and prevention is an essential element for changing behavior.

A study of African American/Black male adolescents from Philadelphia found that a one-time five-hour intervention designed to increase AIDS related knowledge and waken problematic attitudes toward risky sexual behavior was effective. Compared to a control group, at a three-month follow-up assessment, the intervention group had higher AIDS knowledge, weaker intentions to engage in unsafe sexual activity, and reported engaging in less risky sexual behavior in the three months following the intervention. (Jemmott, Jemmott, Fong, 1992). Conversely, Calabrese, Harris, and Easely (1987) found that neither attendance at a safe sex lecture, reading a safe sex brochure, receiving advice from a physician about AIDS, testing for HIV antibodies, nor counseling at an alternative test site were associated with participation in safe sex (Stall, Coates, and Hoff, 1988).

Two one-day peer-led interventions for gay and bisexual men in Philadelphia were evaluated. Intervention 1, a small group “AIDS 101" type lecture was less effective in increasing condom use than Intervention II, which included skills training utilizing role play and group process. Although Intervention II was more effective, both interventions increased condom use for insertive anal sex, but neither had any effect on receptive anal sex (Valdiserri et al., 1989).

A project in Los Angeles that used peer leaders for 4 to 15 bay and bisexual men in groups lasting several hours found that subjects “improved in terms of knowledge, attitudes, and behavioral intentions”. (Institute for Policy Studies, 1993). Effectiveness of one-time condom skills training sessions for women at risk was difficult to assess based on several studies reviewed by Ehrhardt et al. (1995). Fewer women were found to have multiple partners, but the effect on condom use was inconclusive. These authors also reviewed two studies of single session relational skills interventions for STD clinic patients neither of which found impacts on STD reinfection rates.

In a Seattle study of injection drug users, researchers found that a 90 minute educational

intervention did not appear to impact the participants' involvement in high-risk behaviors. There were no significant differences between those who had received the intervention and those who did not at the four month follow-up (Calsyn et al., 1992).

Advantages and Strengths

Single session interventions can be run as one-time skills-building workshops, especially for those people who have been assessed as having knowledge, attitudes, and beliefs favoring risk reduction, but have not changed behavior. A single session format can be also beneficial for groups that cannot commit to multiple sessions and can serve as a first step or launching pad for clients' other prevention-oriented activities, if they focus on creating linkages. Single session presentations can be good for populations at lesser risk that have fairly good information, but want to build awareness and sensitivity (e.g., friends, family, or employers of people with HIV) and can be designed specifically to educate people who might become educators or advocates. It can clarify to people at low risk that they are at low risk, and in this way reduce the demands made on testing centers by people who are just worried about HIV in an unspecified way, not having to do with any actual risk behaviors. Single session groups may be provided in mobile vans, as an effective way of accessing higher-risk groups in their venues.

Considerations

Single session groups are less helpful for people with serious mental health issues; and a single session intervention may also be less beneficial/less feasible for the highest risk populations and those most in denial.

Multiple Session Group Workshops

Multiple session group workshops are a series of workshops, groups, or meetings introducing HIV issues and linking them to other life issues not as easily or immediately understood as relating to HIV. Workshop topics usually build on each other from session to session. Groups may be closed or drop-in, mixed or serostatus-specific, structured or need or issue driven groups for risk reduction and psycho social support. Multiple sessions provide an opportunity to go into greater depth about HIV risk reduction issues and strategies, and this format provides enhanced opportunity for behavior change. The intervention can draw people in with other (not directly HIV-related) activities. Groups can be held in vans or run as before/after bar groups.

Documented Effectiveness

There are much data suggesting that multi-session groups can be very effective at changing the risk behavior of group participants, and certainly at changing their level of knowledge. Multiple sessions have a greater possibility of effecting consistent behavior changes than one-time interventions. They also have more potential to deal with the underlying causes of unsafe behavior. Multiple session groups, however, can be only as effective as the facilitator or teacher who leads them. A facilitator or teacher who is not trained in AIDS education, or is not comfortable speaking frankly about sexuality and drug or other needle use, cannot lead an effective HIV prevention program.

A study of a two-session classroom AIDS education program involving seventh and tenth grade classes in Rhode Island showed positive results. Following instruction, students reported more knowledge, greater tolerance of AIDS patients, and more hesitancy toward high-risk behaviors, but the changes were modest (Brown, Fritz, and Barone, 1989). Similar results were found in a school-based AIDS prevention program presented in an inner-city school in Northern California

serving predominantly African American/ Black and Asian students. In this population, however, changes in high-risk behaviors could not be detected, perhaps due to the small number of sexually active students (Siegel et. Al.). A study of an open-enrollment, pass/fail course at UCLA in 1988 showed positive impact on students' AIDS-related knowledge, attitudes, and behaviors. Compared to the control group, the students who took the lecture course changed their attitudes about critical public policy issues (e.g., mandatory HIV testing) to be in line with current public health policy. The nature of the effect was to bring students toward greater appreciation of 'individual rights' (Abramson, Seckley, Berk, and Cloud, 1989). An evaluation of an AIDS intervention program at a shelter for homeless adolescents in New York demonstrated significant increases in condom use and decreases in risky behavior. The intervention had no effect on abstinence. The intervention focused on skills training, behavior self-management, and group and social support from peers (Rotheram-Borus et al., 1991). A study of African American gay and bisexual men in San Francisco demonstrated that men who participated in multiple session groups had higher levels of behavior change, and maintained behavior change over time than those who attended single sessions groups (Peterson, 1993).

An evaluation of a six-session skill-building intervention conducted with high school student demonstrated that this approach was effective in increasing STD and AIDS knowledge and increasing skills to prevent risky sexual behaviors, but not drug use behaviors (Shafer and Boyer, 1991). In a review of NIMH sponsored research on prevention interventions, the authors outlined several studies that found that multiple session group workshops were successful in reducing high-risk behavior in gay men, women of color, and homeless youth. In particular, reported condom use was much higher for workshop participants than for control groups. These workshops included skill building for assertiveness, relationships, and social support. Multi-session interventions that included a cognitive-behavioral component showed more success in increasing condom use among African American youth than a single session information-only intervention (Office on AIDS et al., undated manuscript).

In their review of interventions for women at risk, Ehrhardt et al. (1995) found evidence that interventions that involved three or more sessions and whose skill-based content was targeted specifically to women (as opposed to men and women) were more successful in reducing high-risk sexual practices, at least in the short term, compared to information-only interventions. Positive results were found for IDU women or sex partners of IDUs and at-risk, inner-city or low income women.

For injection drug users in treatment, participants n an enhanced, sex session intervention on HIV education showed better ability to make decisions about risky behavior immediately following the intervention than participants receiving a single session information intervention. L However, follow-up data did not reflect significant differences in behavior among the two groups (McCusker et al., 1992).

Kelly et al. (1994) were able to demonstrate behavior changes in female patients at an urban clinic who received a five session workshop on HIV/AIDS risk reduction. Participants showed significant changes in condom use and sexual communication and negotiation skills at a three month follow-up. A comparison group receiving health education on other topics showed no change after three months.

Gay and bisexual adolescents participating in an HIV prevention intervention showed changes in their practices of unprotected anal and oral sex. These changes were pronounced for African American youths (Rotherum-Borus et al., 1994).

In addition to the research on HIV prevention interventions, studies on health education interventions for other health concerns also show the effectiveness of a multi-session approach. For example, patients participating in a six session educational program on cardiovascular health demonstrated greater improvements in their lifestyle and diet than did patients receiving the "usual advice" from a health care provider (Lindholm et al., 1995).

Advantages and Strengths

Multi-session groups are most applicable for people with high perception of personal risk is most useful for people who are already highly motivated to attend groups. Structured groups may provide a needed/desired structure for some populations (e.g., some homeless and/or jobless people). Multiple session groups also attract people who perceive themselves to be part of a culture, group, or community, and who are seeking connection with others who have shared experiences and interests. Services may be utilized more fully by women, who tend to take advantage of discussion and support groups and to work well with relational models. The group sessions can also be the first opportunity for people who are unaccustomed to engaging in group activities or to talking about sexual and drug-related behaviors with their peers. Multiple session groups can draw MSMs (many older and Latino MSMs, for example) who are seeking social contacts and support outside of the gay bar scene. Group sessions are especially feasible and easy to integrate when conducted in institutional settings (e.g., youth in schools, clients at in-house treatment centers, and incarcerated persons).

Considerations

Group sessions tend to be more helpful to participants if they are interactive rather than didactic. Providers can encounter difficulty in trying to retain participants for continuing groups; they may require a "hook" other than HIV prevention alone, to motivate regular attendance (note: this is absolutely essential for youth participation). Multiple group sessions may not be feasible for people with limited free time (e.g., people who are struggling to hold onto housing/employment or juggling house, kids, education, work, etc.).

Street and Community Outreach Programs

Street and community outreach programs are defined by their focus of activity and by the content of their offerings. Both have important subcategories of peer and non-peer models.

Peer Education

Peer education involves services provided by individuals who are recruited from a targeted population. These individuals are trained in HIV/AIDS (epidemiology, prevention, resources, etc.), peer counseling, outreach, and the issues of population groups which are difficult to reach with HIV information alone. The peer model can draw on established social networks to disseminate information. Peer providers are a direct link to members of the target population who do not normally present at primary channels such as counseling and testing sites (Edelstein and Gonyer, 1993). Peer education can be used in individual, group and community-level interventions.

The importance of peers as educators is based on Diffusion of Innovation Theory and the subjective norms of the Theory of Reasoned Action. Diffusion Theory suggests that information and learning flows through natural social networks; people are more likely to adopt new behaviors if they are introduced by someone who is similar to them and is perceived to be a role

model (Coates and Greenblatt, 1990; Dorfman et al., 1992). Peer educators may be similar to the target population by behavior, culture, race, age, ethnicity, gender, or other factors salient to the target population.

The Theory of Reasoned Action postulates that the intention to perform self-protective behavior is a function of the individual's attitudes toward that behavior or outcome and the perceived beliefs of the normative peer group. (Fishbein et al., 1994). To promote adoption of positive behavior change, interventions should be directed at the attitudes of the individual toward the behavior and also at the attitudes of the normative group. In other words, individual behavior is dependent in part upon the extent to which the person is influenced by the norms of the peer group.

Since peer norms appear to be important influences on adolescent behavior, peer education can assist in changing the perception of norms with respect to HIV and risk behaviors (DiClemente, 1993). Research has shown that successful adolescent peer educators are able to evaluate AIDS information, reconstruct it, and use their own personal experiences to filter through information. They then pass along this information and advice. Positive peer role models have been successful in helping to bring about risk-reduction changes in individual and group behavioral norms, and in serving as influential models to help young people 's attitudes towards themselves and their health. Peer-based education can also be effective in helping the young person to understand his or her own risk and to translate the significance of this realization into his or her own life and behaviors. This personalization should, however, take place only in a safe setting where self-disclosure is met with acceptance, support, and confidentiality.

Participants in focus groups sponsored by the CPG in 1996 emphasized the importance of receiving information from peers. Peer education plays an important role in helping people perceive their own personal HIV-related risks. Perception of personal risk is an important factor in ultimately changing personal risk behavior.

Demonstrated Effectiveness

Ideally, research evaluating peer programs would measure behavioral outcome in addition to changes in knowledge and attitudes. Additionally, investigations should make direct comparisons between the same interventions using peers and those using non peers. Very few studies have done this. After reviewing a number of evaluation studies on peer education in academic settings, Fennell (1993) concluded that the literature offers little in judging the effectiveness of peer education programs in producing positive behavioral change in students.

Peer education programs have been used extensively in academic settings. They have been shown to be uniquely effective in providing a service with an economy of cost and person power (Zapka and Mazur, 1997). More recently they have been recommended and utilized in HIV prevention programs as a method for outreach, counseling, and changing norms. Peers can act as valuable change agents because they can communicate in ways that professionals cannot, and act as trustworthy role models (Perry, 1989). Persons are better able to accept communications that may influence attitudes, norms, and behaviors if ; they perceive the communicator is someone with whom they can identify and who may share similar problems (Sloane and Zimmer, 1993).

AIDS research has produced good evidence for conducting peer-led interventions. Rickert and colleagues (Rickert, Jay, & Gottlieb, 1991, cited in Sloane & Zimmer, 1993) compared a peer-led versus an adult-led AIDS education intervention with adolescents and found that participants asked more questions or peer leaders than of adult presenters. They concluded that perceptions

of personal risk may be affected more any peer presenters than by adult presenters.

Kelly and associates (Kelly, St. Lawrence, Brasfield, Kalichman, et. Al., 1991) found that a peer-led intervention reduced the number of participants who engaged in unprotected anal intercourse. They concluded that interventions that employ peer leaders to endorse change may produce or accelerate population behavior changes to lessen risk for HIV infection. In a later study, researchers (Kelly et. al., 1992) produced similar findings. They reported that a peer-led outreach intervention targeting gay men frequenting bars resulted in a marked decrease in the proportion of men engaging in unprotected anal intercourse. Jemmott and Jemmott (1991) found a significant relationship between future intentions to use condoms when participants had support from parents or sexual partners for condom use.

Groups led by peers may be more effective at motivating behavior change than those led by non-peers. Catania et. al. (1991) found that positive support from friends, family, and lovers is related to changes in sexual behavior and increased condom use whereas helpful support from more formal sources (e.g., physicians, psychologists, etc.) was not associated with changes in condom use.

Using peers as educators may be useful for helping targeted population more accurately perceive their personal level of HIV-related risk. Peer educators can positively effect group norms, and peer educators are better able to talk frankly about sensitive issues around sex and drug use. Eroticizing condom use and emphasizing the erotic appeal of safer sex are critical components of interventions designed to change sexual behavior (Catania, et. al., 1991). Peer educators may be better equipped to understand what a particular group may or may not find erotic.

An additional benefit of peer-led programs is the positive effect they have on the peer educators themselves (McLean, 1994; Sloane & Zimmer, 1993; Stevens, 1994). Because they undergo training which involves increasing HIV risk knowledge, sensitivity and skills training, studies report increased prevention behaviors in the peer leaders in addition to the garget populations (McLean, 1994; Sloane & Zimmer, 1993; Stevens, 1994).

The effectiveness of peer programs is dependent upon the quality of the support and training of peer-leaders and the implementation and delivery of the program and its messages. Efforts can and should be made to control and maintain quality throughout the life of the program with ongoing-evaluations of service delivery and of outcomes (Croll, Jurs, & Kennedy, 1993). Only ongoing monitoring and outcome evaluation can help identify training needs in delivery sensitivity of peer leaders, and assess the impact of the interventions that are implemented (Croll et. al., 1993).

Advantages and Strengths

Peer education as a strategy is generally applicable to all populations, with a few exceptions. It is especially suited for populations who do not initially perceive themselves to be at risk.

Considerations

A peer approach may not appeal as much to members of small/close communities where information travels fast and stigma may still be attached to HIV concerns. Some groups may prefer to receive HIV prevention services form people they view as outside of their immediate community, so that they can talk more freely and not fear leakage of information. Peer education may not be appropriate for individuals desiring anonymity. Confidentiality should always be emphasized.

Street and Community Outreach

Street and community outreach refers to HIV prevention education and counseling that is delivered at informal sites where persons engaged in high-risk activities congregate, such as streets, bars, parks, shooting galleries, bathhouses, beauty parlors, etc. The strategy involves a broad range of models, from occasional condom drops to the long-term placement of highly skilled workers in the community. Street and community outreach programs may be highly interactive and engaging, or they may involve only a cursory risk message and delivery of referral information. Some outreach programs strive to develop long-term relationships with individuals on the street, thus the service s repeatedly delivered to an individual over time.

Street outreach involves more than the distribution of condoms and bleach. The more difficult task of the outreach workers is encouraging lifestyle changes by developing relationships through repeated outreach and a continuous presence. Not surprisingly, studies have found that increased exposure over time results in more significant behavioral changes (Stephens, et., al., 1993). However, the same studies have also indicated that there were not significant differences in behavioral changes based on the level of intensity of the intervention. Other studies of outreach projects, however, including a report by the Centers for Disease Control on AIDS community development project, indicate that the presence of outreach workers needs to be consistent and continuous, not just sporadic visits (Johnson, et. al., 1990; Stephens, et. al., 1993; Dorfman et. al., 1992).

A study of enhanced vs. standard interventions indicates that there is some, but not major, difference between the responses to the enhanced and standard interventions offered. Their recommendation is that more and not less enhanced intervention would make an outreach program more successful. The CDC study also confirms this analysis: “Counseling oriented interventions may need to address other issues or behaviors in an individual’s life (such as childbearing plans among female sex partners of IDUs; crack use among IDUs; addiction to injectable illegal drugs; and alcohol abuse among gay/.bisexual men) before HIV prevention can be effectively addressed (CDC, 1992).

Street outreach workers may become trusted health care professionals. Lack of transportation and an intimidating appointment system can be a barrier to historically under served risk groups receiving HIV counseling and testing as well as STD and other health care services. Street outreach workers bring the services to the streets instead of asking people to make a production of getting to a clinic. Information that is presented in pamphlets kept at health clinics or broadcast through other media sources such as newsprint and television are less likely to impact historically under served individuals engaging in high-risk behaviors on the streets. The street outreach workers make it easy to get information by being accessible and available instantly (Wattersers, et. al., 1990).

In a study of community-based outreach to urban sex workers conducted by Dorfman, et. al., (1992) it is noted that the dedication of street outreach workers was noticed and appreciated by the community. Johnson, et. al., (1990), in their analysis of 28 street outreach programs around the country, conclude that the success or failure of community-based HIV prevention programs is dependent on the skills and dedication of the outreach worker.

Field staff should be indigenous to the community. It is important that outreach workers can relate to their contacts. It is important for street outreach workers to know when people are approachable. It is well documented from the earliest studies involving outreach that it is

important for outreach workers to speak the same language (including the slang/jive of the community) and come from the same ethnic and socioeconomic background as their contacts. Reports indicate that street outreach workers are more readily trusted if they have at some point in their lives experienced the activities that they are talking about (Dorfman, 1992).

Different types of outreach strategies work in different types of communities. One study compared proactive and reactive strategies of street outreach. Proactive outreach consists of cold calls, walking up to people and making an introduction and actively initiating contact and interacting with individuals. Reactive outreach is a more passive form of outreach. This type of street outreach involves a constant community presence. Outreach workers "hang out" and are available for people to approach with questions. With this technique, the contacts have control over when outreach happens. The conclusion of the study indicated that different strategies worked for different risk groups. The proactive style was used most frequently within African American/Black communities by black outreach workers. The reactive strategy "emerged as a calculated response to the idiosyncrasies of particular communities...The black, Hispanic, and gay multi-ethnic neighborhoods differ in their general willingness to openly acknowledge and discuss drug abuse, illness and HIV-related diseases...The emergence of a proactive style of outreach in the black community was appropriate to the setting. On the other hand, the Hispanic community generally views drug abuse and HIV related diseases as taboo subjects" (Johnson, 1990).

Demonstrated Effectiveness

Research data, focus group participants, key informants, and providers all emphasize that outreach services must be appropriate to the target population and its norm. Clients should be able to identify with outreach workers. For example, research shows that using outreach workers from the community contributes to the positive impact of outreach programs targeting IDUs (Coates and Stryker, 1994).

Several studies discuss the effectiveness of outreach programs and of the core elements that influence that effectiveness. Researchers state that the most critical factor to effectiveness is the outreach staff themselves Staff field workers, as much as pamphlets, condoms, and bleach handed out, need to be considered as intervention strategies in themselves. For an outreach program to be effective, the staff delivering the intervention needs to be respected, trusted, credible, open, friendly, dedicated, non-threatening, and non-judgmental. Once such trust is established, however, the results can be impressive. In one study of 554 IDUs in San Francisco, almost one quarter (24%) reported learning about bleach use from a community health outreach worker (Wattersers et. al., 1990).

Research and other data show street outreach is successful in communicating prevention messages to many populations and is associated with behavior changes, especially when it involves peer leaders, targets particular communities, and reaches them near the location of risky behavior (Givertz and Katz, 1993; Wattersers, et. al., 1990).

It is notable that street and community-based outreach services are the only intervention proven in published research to be somewhat successful with youths, one of the most difficult groups to reach with prevention messages (Givertz and Katz, 1993). Additional research has shown that staff who were from the targeted community and population were more likely to gain access to sex workers and became role models for behavior change (Dorfman, et. al., 1992). Building trust with members of the target population has been found to be an important factor for continued participation of the target population (Dorfman, et. al., 1992).

Erhardt, et. al.'s (1995) review of interventions for at-risk women found an increased condom use among female sex partners of IDUs living in housing projects who were the target of outreach efforts. A review of HIV prevention interventions by Choi and Coates (1994) found only three studies reporting on the effectiveness of community outreach to commercial sex workers; all showed increased condom use. In addition, the authors found two studies looking at street outreach to out-of treatment IDUs that found the intervention to be effective in reducing needle sharing and to a lesser extent, increasing condom use.

Advantages and Strengths

Outreach is especially appropriate for populations who 1) have a low perception of personal risk for HIV; 2) lack of access to health and social services; and 3) need basic information. Outreach can also serve as an opportunity to recruit clients targeted for other prevention activities. Additionally, the Center for AIDS Prevention Studies (CAPS) at UCSF lists community outreach as an effective approach leading to changed behaviors among IDUs.

Considerations

Outreach may not be suitable for individuals with serious mental health stressors. It is not as appropriate for populations that are well-informed but continue to show high rates of infection. Outreach may not be appropriate or allowed in certain venues; the needs assessment can help to determine the feasibility of outreach and the intervention may lose its impact if it is over-concentrated in a venue. After saturating a venue over a period of time, the intervention needs to adapt.

Condoms, Latex Barriers, Bleach Distribution

Through this strategy, health workers distribute bleach, condoms, and risk reduction barriers; demonstrate their use; and provide referrals in areas where people at risk for HIV congregate. Limited opportunities for one-on-one health education or risk reduction are offered by this strategy, which by definition, focuses on behavioral changes.

Access to Sterile Injection Equipment

Needle exchange programs provide sterile needles to injection drug users, and to hormone, steroid, vitamin, and insulin users. Needle exchange programs are community or street-based. Within this intervention framework, prevention workers distribute clean needles (syringes) and other supplies to individuals who use needles to inject drugs, usually in exchange for used needles. They also provide referrals to HIV-related services in areas where persons involved in high-risk behaviors congregate. A limited opportunity for one-on-one health education and/or risk reduction intervention may occur in this context, as may a chance to help link an infected possible infected person to HIV care services. Needle exchange programs focus specifically on behavior change related to needle usage, and less on sexual behaviors. Needle exchange programs are designed to reach individuals on a repeated basis.

A variety of factors may limit the effectiveness of needle exchange programs, including a lack of resources and of information in target communities about existing services. Providers note that overall, only a fraction of IDUs use needle exchanges. And IDUs who would utilize needle exchange programs do not always know how to access them. Providers say IDUs fear that law enforcement officials or social service authorities will intercept them at needle exchange sites. Providers also say that some women IDUs fear their children will be taken from them if they participate in needle exchange programs.

Demonstrated Effectiveness

The majority of studies demonstrate decreased rates of HIV drug risk behavior through needle exchange, but not sex risk behavior. Available data do not provide evidence that Needle Exchange Programs change overall community levels of drug use (Lurie & Reingold, 1993). There is also evidence to suggest that laws restricting access to syringes can potentially increase HIV infection rates.

Perinatal Transmission Prevention Activities

Between 1994 and 1998, the provision of antiretroviral therapies during the perinatal period resulted in substantial decreases in mother-to-child transmission of HIV from 20-25% to 5-10%. Despite this important success in HIV prevention, there are still groups of women and infants in the United States who do not benefit from antiretroviral therapy.

Studies have indicated that not all providers are offering HIV testing to all their prenatal patients. A CDC study found that one of the major reasons for women not accepting testing was that they did not perceive that their provider thought it was important. It has also been shown that private providers are less likely to offer HIV counseling and testing than are public setting providers. The Institute of Medicine's (IOM) recent report recommended that prenatal HIV testing be universal among pregnant women and become a routine part of prenatal care recommended by all providers. Women who may not be accessing these services include, among others, those who are abusing substances, incarcerated, undocumented, non-English speaking, uninsured, homeless, teens, and those who are unaware of, or in denial about their risk for being HIV-infected. The infants of these mothers also are not receiving services and may include additionally those who are orphaned and abandoned.

Several services must take place to assure the lowest risk of perinatal HIV transmission. Missed opportunities at any point may increase the risk of transmission. The services needed to reduce perinatal transmission includes:

- prenatal care,
- education about the importance of HIV testing,
- voluntary HIV testing,
- for those who test positive, post-test counseling and zidovudine (ZDV) to reduce perinatal transmission,
- antiretrovirals for the benefit of the women's own health,
- other HIV-related prevention and care services during the perinatal period, and
- avoidance of breast-feeding to prevent HIV transmission to infants.

Access to STD Diagnosis and Treatment

The intimate inter-relationships between HIV infection and other sexually transmitted diseases are clear: the organisms are transmitted in similar fashions, many of the same populations are involved, other STDs increase the risk of HIV transmissions at least 2-5-fold, STD treatment may reduce HIV incidence, and HIV infection alters the natural history and response to standard therapy of several STDs. Behavior modifications to avoid risk-taking such as using condoms correctly and consistently, decreasing the number of one's sex partners, becoming monogamous, reduces the risk of transmission of HIV and other STDs. Despite these similarities, STDs and HIV infection are often looked upon as distinct and separate problems. Although STD diagnosis and treatment is funded primarily through the STD prevention cooperative agreement, there clearly should be a close programmatic collaboration and linkages between HIV and STD

prevention programs, especially when there is a high incidence of both problems. HIV prevention programs need to develop close linkages with STD prevention programs to ensure STDs are diagnosed and referred for treatment. When feasible, applicants should try to offer onsite, at counseling and testing sites, diagnostic services and referrals for treatment of other STDs. Closely coordinating HIV prevention and STD prevention services is necessary and cost-effective and should be accomplished to reduce the transmission of HIV and other STDs. As of June 2000, the STD and HIV/AIDS programs were administratively combined into one HIV/STD section.

School Based Programs

Public Health Reports, 1994, found that some, but not all, HIV and sex education programs delayed the initiation of sexual intercourse, reduced the frequency of intercourse, reduced the number of sex partners, or increased the use of condoms or other contraceptives. No program was found to increase sexual activity.

A review of effective curricula indicates that they share the following characteristics:

- A narrow focus on reducing specific sexual risk-taking behaviors that may lead to HIV infection, other sexually transmitted diseases (STDs), or unintended pregnancy.
- Use of the four components of social learning theory (knowledge, motivation, outcome expectancy, and self-efficacy) as a foundation for program development.
- Provision of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse.
- Instruction on social and media influences on sexual behaviors.
- Reinforcement of individual values and group norms against unprotected sex.
- Activities to increase skills in communicating and negotiating, as well as confidence in these skills.

Ineffective curricula covered a broader array of topics, but failed to emphasize those particular facts, values, norms, and skills needed to postpone sex or avoid unprotected sex. Ineffective curricula also taught decision-making skills, but did not explicitly guide students to make health-enhancing decisions. Schools can help reduce HIV, STDs, and unintended pregnancy. To ensure success, however, schools should implement programs that have been proven effective or that incorporate the key features of effective programs.

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